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Reader's Guide

The first issue of Volume Forty-Two ushers in a new development. Henceforth, the titles of some of the main articles being featured in each issue will be indicated on the cover. Watch the blue dots! This month we bring you not just a three-way but a five-way discussion on various aspects of tuberculosis. The very clear description of the thoracoplasty technique by **Dr. G. H. Hames** starts the series. Dr. Hames is associated with the Saskatoon Sanatorium. When the analysis of nursing care following thoracoplasty was written, **Elsie (Towers) Peacock** was nurse-in-charge of the surgical ward at the Sanatorium and **Helene Kirkpatrick** was senior nurse. **B. M. Evjen,** who gives us an insight into the patient's reactions, is also a graduate nurse. **Esther Paulson** is the efficient supervisor of the Vancouver Unit of the British Columbia Division of Tuberculosis Control. **Grace Giles** is travelling instructor for the Saskatchewan Registered Nurses Association.

We are exceedingly grateful to the *American Journal of Nursing* and to the authors for their gracious permission to bring all of the nurses of Canada the thought-provoking discussion of the place nursing holds in the world of professionalism. Both **Genevieve Knight Bixler, Ed.D.** and **Roy White Bixler, Ed. D.,** have had close contact with nursing and nursing education. Both have done numerous surveys in the latter field and are thoroughly familiar with the needs, progress, and problems confronting nursing today.

Lillian Thomson has as sincere an appreciation of the value of the public health nurse's work as she has knowledge of the opportunities which await the social worker. This understanding has grown out of her long contact with both groups and in particular through her association with both as instructor at the University of Alberta. Miss Thomson is now with the Y.W.C.A. National Office in Toronto.

Many thoughtful and exceedingly useful papers are prepared each year by advanced students in the various University Schools of Nursing. We are fortunate in being able to secure some of these to share with our readers. The strong plea which **Isabel (Snyder) MacDougall** makes for more general staff nurses in our schools of nursing was prepared while she was attending the McGill School for Graduate Nurses. Mrs. MacDougall is a graduate of the Montreal General Hospital and worked on the night staff there for some time. Dr. MacDougall has recently returned from overseas.

Hundreds of nurses who had retired from active work have returned to serve faithfully in our exceedingly busy and pressed hospitals. **M. MacLeod** stepped in to assist in Saskatoon and, from her account of her experiences, thoroughly enjoyed getting back into harness.

Not all of the concern for the functioning of our hospitals and the wellbeing of the patients rests with the nursing and medical staffs or even with the boards of directors. Fortunate, indeed, is the hospital which has a vigorous women's auxiliary to lend help when needed. **Jane Hogarth,** who has outlined for us the possibilities of this form of organization, is supervisor of one of the private floors at the McKellar General Hospital. **Mrs. A. V. Sinclair** is president of their Ladies' Aid.

At two, our promising cover lad thinks a pile of snow is just exactly the right spot for a happy frolic. As the years unfold, his birthright of sturdy health and vigour will help him to jump into every problem as eagerly as he now prepares to dive into the snow.

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J. Obstet. Gynaec. Brit. Emp.,
Vol. 39, No. 7.

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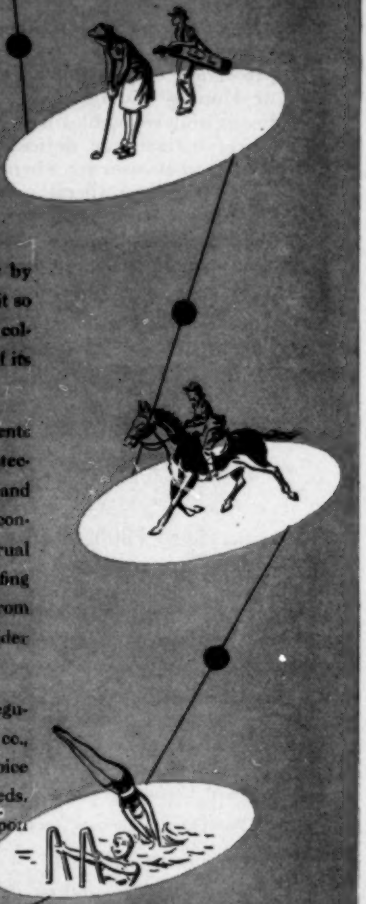

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REFERENCES: 1. West. J. Surg. & Gyn., 51:150, April, 1943. 2. Clin. Med. & Surg., 46:327, August, 1939. 3. Am. J. Obst. & Gynec., 46:259, 1943.

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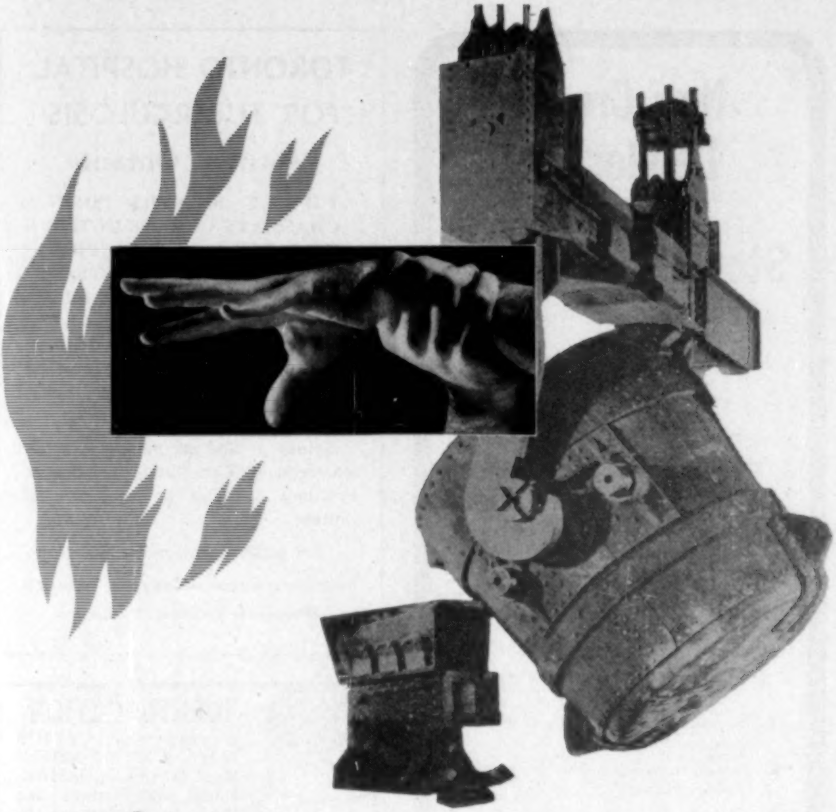

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[1] J. A. M. A., *128*:475-479, June 16, 1945.

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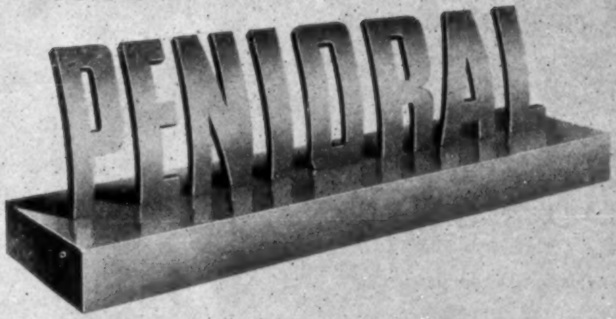

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A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-TWO NUMBER ONE

JANUARY 1946

New Year's Greetings

"Thus times do shift — each thing his turn does hold
New things succeed, as former things grow old."

With V-E day and V-J day passed and the high hopes we then had fading rapidly in the face of the gloomy pictures so constantly presented by press and radio dare we wish ourselves a Happy New Year? And having wished it, how do we make it come true? We have been proud and happy to welcome back so many of our nurses from overseas and are proud and happy that others are working with UNRRA in occupied countries. We are proud and happy too that active nurses in Canada have been able to maintain nursing services at home. But times do shift and what has served in the war years is no longer adequate.

In England and in the United States the shortage of nurses is still acute. In Canada the situation remains serious. In all three countries there is fear that the practical nurse through attempting to meet a public need will usurp the work which the professional nurse claims as her right.

The young nurses of today whether they realize it or not are moulding the future of nursing. It is true that each has a responsibility to herself and to her family but there is also the larger responsibility to her profession and to the community. And only by nurses satisfying the community will support be gained for our profession and for the type of preparation which we think the profession should have. If sufficient nursing service to the community (and this includes hospitals of course) is not available or is given unwillingly then the practical nurse, with little or no preparation, will be called in to provide what help she can.

For the New Year then should each one not set her own house in order by working if possible where and when there is need, by moving less frequently from place to place and from position to position, by finding out what others are doing and why, by attending meetings and actively assisting her professional organizations and through reading and study enlarge her knowledge and so do a better job. Thus will the New Year be made a better and happier one.

Fanny Munroe
President
Canadian Nurses Association

Alumnae Sponsors Competition

Bearing out the oft-repeated premise that the *Journal* belongs to the nurses of Canada, the action of the Alumnae Association of the University of Alberta Hospital in sponsoring an essay competition among the student nurses and alumnae members wins our hearty appreciation. Such co-operation as this is not only heart-warming to the editor but demonstrates a keen interest in the promotion of the *Journal*. We hope that other alumnae associations will establish some similar means of focussing attention on the *Journal*. The rules of the contest are as follows:

1. All graduates of and students at the University of Alberta Hospital are eligible.
2. Students' articles will be judged separately. The best one will receive $10. "Honourable Mention" articles will receive subscriptions to *The Canadian Nurse*.
3. The best article by a graduate will be awarded $10. All graduates must be subscribers to *The Canadian Nurse* before they are eligible.
4. A pen-name must be used, to appear at the top of each page. Pen-name and real name must be enclosed in a sealed envelope.
5. Winning articles will be submitted to *The Canadian Nurse* for publication.
6. The judges will be: Miss P. Wyld, instructress, University Hospital; Miss Helen McArthur, superintendent, Public Health Nursing Branch, Department of Public Health, Alberta; Miss Madeline McCulla, acting director, School of Nursing, University of Alberta; Mrs. R. Sellhorn, supervisor, V.O.N., Edmonton.
7. Articles preferred are those describing the nursing care of a specific disease — bedside, home care, as well as the social aspects. Those wishing to write other types of articles are encouraged to do so.
8. The contest closes April 30. All entries should be sent to *Miss P. Wyld, University of Alberta Hospital, Edmonton.*

Preview

What is the present day knowledge and treatment of Diabetes Mellitus? With a fairly well informed public, it is highly important that there should be no gaps in the nurse's information on this topic. We have much pleasure, therefore, in promising our readers a valuable series, including a general description of the disease by Dr. F. Gerard Allison; a detailed account of essential nursing techniques by Florence M. Wilson, B.Sc.; and an insight into the public health nurse's responsibilities by Isobell Barron. These will appear in the February number.

Thoracoplasty

G. H. Hames, B.A., M.D.

The most significant advance in the treatment of pulmonary tuberculosis in recent years has been the widespread application of procedures designed to collapse the diseased lung. The value of the operation of thoracoplasty in the collapse therapy program has become firmly established because of the high percentage of successful results obtained in a large group of patients whose outlook for recovery otherwise is extremely poor. The operation involves the extensive resection of a variable number of ribs and results in a permanent collapse of the underlying lung. As the periosteum of the ribs is not removed, regeneration of bone eventually occurs to restore the rigidity of the chest wall, while maintaining the lung in its collapsed position. Although the idea of collapsing the lung by resection of ribs originated in Europe in the latter part of the nineteenth century, the modern type of operation, based on modifications recommended by the American surgeons, Ochsner, Hedblom and Alexander, has only been widely used since 1932. An excellent review of the history and evolution of the operative procedure is given by Alexander.* The modern type of operation is based on two important changes in procedure:

1. Division of the total resection of ribs into several stages — usually not more than three ribs being resected at one stage.

2. Resection of great lengths of the ribs directly overlying the diseased portion of the lung, while preserving as much normal functioning lung as possible. The type of operation in vogue prior to these modifications involved the resection of relatively short segments of the posterior parts of the upper eleven ribs, carried out in one, or at the most, two stages. The division of the operation into multiple small stages was followed by a marked reduction in operative mortality. The increased safety of operation permitted the resection of much longer segments of rib, thereby more effectively collapsing the diseased lung. The majority of patients requiring thoracoplasty have disease limited to the upper portion of the lung. Therefore, resection of great lengths of only the upper seven or eight ribs will usually be sufficient, and functioning lung tissue at the base is not sacrificed as in the older types of operation. If the base of the lung is diseased, and especially if it contains cavities, a total thoracoplasty will, of course, be necessary. In a few patients with disease limited to the extreme apex of the lung, a five or six rib thoracoplasty may be sufficient. The degree of collapse resulting from the modern type of operation is productive of many more successful results than the older types of thoracoplasty.

Operative Procedure

Only a brief outline of the operative procedure will be given before discussing the indications for, and results of, operation. The operation is usually carried out under either local, or general inhalation, anesthesia. In the former case, the skin and muscles along the line of incision are infiltrated with novocaine 1/2 per cent and the intercostal nerves blocked with novocaine 1 per cent. Local anesthesia may be used advantageously for patients who have large amounts of sputum where retention of the cough reflex throughout the operation may be important. The ability to clear the tracheobronchial tree of secretions throughout the operation lessens the chance of spilling over into the contralateral lung, which is one of the hazards of operation. Of the inhalation anesthetics, cyclopropane is probably most frequently used at the present time. For patients with pulmonary disease, it has the advantage of permitting the administration of a high percentage of oxygen throughout the operation.

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*Alexander, John: The Collapse Therapy of Pulmonary Tuberculosis, Springfield, Ill., 1937, Charles C. Thomas.

In the majority of instances, all the rib resection necessary can be carried out through posterior incisions. The patient is placed on the operating table in the lateral position with the side to be operated on uppermost. The head of the table is tilted in the Trendelenburg position to encourage drainage of secretions towards the pharynx. If the upper seven or eight ribs only are to be resected, one incision is sufficient. This extends from just below the top of the shoulder downwards midway between the scapula and the spine to the inferior angle of the former, where it turns laterally and extends to the mid-axilla. Following division of muscles extending from the scapula to the spine and the chest wall, the scapula is readily retracted, and through this incision the entire length of the upper ribs may be resected. However, under certain circumstances it may be considered wise to remove only the posterolateral portions of the upper ribs at the first stage of the thoracoplasty. In this event, the anterior stumps are removed through an incision paralleling the sternum or in the axilla at a later date if considered necessary. At the first stage, usually all of the first rib and the greater portion, if not all, of the second and third are removed. In patients whose general condition is poor and respiratory reserve impaired, it may not be safe to resect great lengths of even three ribs. In others with rigid lungs and pleurae, it is possible to safely resect as many as four or five ribs at one stage. The ribs are removed by incising the periosteum on the outer surface and separating it from the rib by periosteal elevators. The rib itself is then sectioned with bone cutting forceps leaving its periosteal covering in place. Care must be taken to avoid injury to the lung or pleurae which might lead to deep wound infection, a very serious complication in thoracoplasty. In removing the first rib, caution must be exercised to avoid injuring the brachial plexus and subclavian vessels which lie in close approximation with its inner edge. If only seven or eight ribs in all are to be resected, the subsequent stages can be carried out by re-opening the original incision. If a total thoracoplasty is necessary, the lower ribs are removed by a new, suitably placed, posterior incision. As the maximum collapse is not accomplished until after the final stage of the operation, too rapid regeneration of bone from the periosteum of the upper ribs might interfere with the best collapse possible being secured. The regeneration of bone can be delayed by swabbing the periosteum with 10 per cent formalin. The interval between stages averages three weeks. A longer interval, necessitated by the patient's condition, or perhaps by a wound infection, may prevent an efficient collapse, especially if the periosteal beds have not been formalinized.

INDICATIONS FOR OPERATION

In the great majority of instances where thoracoplasty is recommended, the chief indications for operation are two in number:

1. The persistence of a cavity in the lung after an adequate trial of sanatorium treatment with or without the use of temporary collapse therapy measures such as pneumothorax, or phrenic paralysis. This is by far the most common single indication for operation.
2. Tuberculous empyema.

Pulmonary tuberculosis, uncomplicated by cavity formation, as a rule responds well to sanatorium treatment alone. However, the appearance of a cavity at once increases very considerably the difficulties of treatment and the seriousness of the prognosis. While of the greatest importance in the general treatment of tuberculosis, the sanatorium regime alone is ineffective in leading to the arrest of the disease in the presence of cavities, in a high percentage of cases. The addition of collapse therapy to the sanatorium regime has been responsible for restoring to health large numbers of patients who otherwise would not have recovered. Temporary collapse of the lung by a pneumothorax is the most frequently applied collapse procedure and where a satisfactory pneumothorax can be induced, control of the disease is very effective. However, it is sometimes impossible to induce a pneumothorax at all, as the result of widespread obliteration of the pleural space due to a previous pleurisy. In other instances, a partial pneumothorax can be obtained, but localized adhesions over the diseased area prevent an effective collapse. If these adhesions are of such a nature that they cannot be safely divided by the operation of pneumonolysis, continuance of the pneumothorax is, as a rule, inadvisable. In recent years, the complication of pulmonary tuberculosis by bronchial stenosis, resulting from tuberculous ulceration, has been recognized more frequently by the use of bronchoscopy, which is becoming almost routine in some institutions. Pneumothorax, in the presence of a marked stenosis of a major bronchus, is attended with the risk of serious pleural complications, and may be quite ineffective in closing cavities. Evidence is accumulating to indicate that in such cases superior results can be achieved by thoracoplasty.

Tuberculosis empyema is, in most instances, a complication of pneumothorax, and is, therefore, associated with some degree of pulmonary disease. Usually the pneumothorax has existed for some considerable time before the onset of the empyema. Conservative treatment by frequent aspirations of pus is directed towards encouraging re-expansion of the lung in order to obliterate the empyema space. Due to fibrosis within the lung, or a great thickening of the pleurae, re-expansion may be impossible and a very extensive thoracoplasty is necessary to obliterate the empyema space. If the disease in the lung has not been controlled, and especially if an open cavity is present, attempts to re-expand the lung may be inadvisable. Therefore, thoracoplasty is indicated both to control the pulmonary disease, and to obliterate the empyema.

From what has been said, it will be obvious that candidates for thoracoplasty are drawn from that group of patients in whom sanatorium treatment alone, or temporary collapse measures, have failed to control the disease. It should be stressed, however, that while these measures may be ineffective in leading to arrest of the disease, they are often of the greatest importance in bringing about sufficient improvement to allow a thoracoplasty to be done.

SELECTION OF PATIENTS

The evolution of the modern type of thoracoplasty, with its low mortality and more effective collapse, has considerably increased the use of the operation. Nevertheless, considerable judgement and experience are necessary on the part of both physician and surgeon in selecting patients suitable for operation. The ideal patient is the young adult between the ages of twenty and thirty-five, whose disease is unilateral, whose toxic symptoms have subsided, and whose serial x-ray films show stationary or retrogressive disease with some evidence of healing. Acutely ill patients with extensive progressing disease are not fit for thoracoplasty. Disease in the contralateral lung does not contra-indicate operation provided that it is not so extensive as to seriously impair the respiratory capacity, and has not shown a recent exacerbation. Control of the disease in the better lung by pneumothorax or some other collapse procedure may eventually permit thoracoplasty on the worst side. Thoracoplasty should not be done in the presence of active and progressive non-pulmonary complications such as laryngitis, intestinal tuberculosis, or bilateral renal tuberculosis. Milder degrees of laryngitis and intestinal disease do not contra-indicate operation because these conditions often improve rapidly after control of the pulmonary lesion. Conditions such as cardiac disease with failure or renal insufficiency contra-indicate operation. Patients who are short of breath in bed or on slight exertion are not good subjects for thoracoplasty because they are almost certainly likely to be more short of breath afterwards, and may suffer a severe disability for this reason, even though the pulmonary disease has been controlled by the operation. A considerable number of patients between the ages of forty and sixty have been subjected to thoracoplasty, and while many excellent results have been achieved, discrimination is necessary in recommending operation on these older patients, particularly those over fifty. Many of them have had tuberculosis for a long time and, as well as the chronic toxic effects of this disease, are subject to the degenerative processes that occur with advancing age. In our experience, they have usually withstood the operative procedure itself very well, but their convalescence is slower, and more difficult, and they are more likely to suffer disability due to shortness of breath than the younger group of patients. Children and adolescents also stand the operation well. However, they have a definite tendency to develop a scoliosis following operation which may lead to severe deformity. Careful attention to posturing and exercises in the immediate post-operative period may prevent, or at least limit, the degree of such a scoliosis, so that the patient is not handicapped.

In considering the results of thoracoplasty, there are a number of factors which must be assessed in evaluating the final usefulness of the operation. In dealing with a disease that is as fatal as moderately or far advanced tuberculosis with persisting cavities, one perhaps should not be too concerned about operative mortality. Nevertheless, reports from various clinics have shown that the modern type of thoracoplasty is associated with a low mortality rate. The minimum of 5 per cent deaths directly or indirectly due to operation, laid down by Alexander in 1937, should perhaps at the present time be reduced to around 3 per cent. At least 85 per cent of patients operated on should be living five years after operation. The two most important criteria of success are the frequency with which the disease is arrested and the number of patients who can be rehabilitated. As regards arrest of disease, the modern operation should close cavities and render the sputum negative in at least 80 per cent of patients operated on. The efficacy of the operation in rehabilitating patients is indicated by the fact that from one-half to two-thirds of patients are discharged from the sanatorium one year after operation. Periodic reviews of our thoracoplasty patients reveal that roughly two-thirds of the discharged group are doing full-time or part-time work, or are able to work. Without operation, the group of patients now treated by thoracoplasty would require years of sanatorium treatment and probably not more than 10 per cent would be living in five years. If not confined to a sanatorium they would constitute foci of infection for spread of the disease in the community.

The results that are being achieved by thoracoplasty are, therefore, significant not only from the viewpoint of the individual patient's chances of recovery and rehabilitation, but also in regard to the economic and public health aspects of the tuberculosis problem in general.

Thoracoplasty Nursing Care

ELSIE TOWERS PEACOCK *and* HELENE KIRKPATRICK

In the past twenty-five years thoracic surgery has undergone a rapid development and at the present time, in almost any large hospital, the nurse may encounter a considerable variety of major surgical procedures utilized in the treatment of diseases of the thoracic viscera. The treatment of pulmonary tuberculosis has shared in the advances made in this field of surgery. In the modern tuberculosis sanatorium the most frequently performed major surgical procedure is the operation of thoracoplasty by which a permanent collapse of diseased lung tissue is accomplished by the removal of the overlying ribs. The operation has been used with increasing frequency in the past fifteen years following modifications in procedure which have reduced operative mortality and increased the percentage of successful results.

Expert nursing care plays a most important part in the successful surgical treatment of tuberculosis. As well as being familiar with the signs of such emergencies as hemorrhage, shock, embolism, which are common to surgery in general, the nurse must have a knowledge of certain special hazards associated with operations on the lungs and thoracic wall. It is the purpose of this paper to discuss some of the special aspects of nursing care in thoracic cases as they apply to the operation of thoracoplasty. The nurse in charge of thoracoplasty patients should be familiar with the common symptoms and the course of tuberculosis, and she should know the essential facts regarding disturbances of the mechanics and physiology of the thorax which result from the removal of ribs. An appreciation of the differing temperaments and reactions to illness of patients may be of great assistance to her in estimating the significance of various symptoms and signs in the post-operative period. As the member of the staff most constantly and intimately in contact with patients, the nurse's ability to recognize early the symptoms and signs of potentially serious complications may be of the greatest importance in post-operative care.

PRE-OPERATIVE PREPARATION

Usually there is an interval of weeks or months between the time that it becomes evident that a thoracoplasty will be necessary and the actual performance of the operation. During this interval every effort is made to improve the patient's general condition and initiate the process of healing by the well-recognized principles of sanatorium care. Prior to the final decision regarding the advisability of thoracoplasty, various clinical and laboratory studies will have been carried out, including blood examination, estimates of cardiac and respiratory reserve, renal function tests. On the basis of these the patient's fitness for operation and the optimum time for operation are decided. As the time for operation approaches practically all patients are allowed limited walking exercise because it has been found that their general physical tone and cardio-respiratory reserve are much improved thereby. In the immediate pre-operative days, a high caloric, high protein diet is provided, with a vitamin supplement. As the operation is associated with considerable loss of blood a hematinic, usually ferrous sulphate gr. 5, is administered three times a day if anemia is evident. In the occasional patient whose hemoglobin and red blood cell count do not reach a satisfactory level a blood transfusion is given before or during operation. The ferrous sulphate is continued throughout the operative period. The nurse should see that all patients receive and drink not less than 2500 cc. of fluid in the days preceding operation. On the day before operation several glasses of fruit juice, with extra glucose, are given.

Twenty-four hour amounts of sputum should be measured for several days preceding operation, so that both the nurse and surgeon will better be able to estimate in the early post-operative period whether the patient is efficiently evacuating sputum. If a large cavity is present it is not likely that the first stage, or possibly the second, will appreciably decrease the amount of sputum produced. Nevertheless there is often an apparently lessened output of sputum in the first 24 or 48 hours. This is not necessarily the result of an actual reduction in the amount of sputum produced but may be due to interference with the drainage of sputum from the cavity to the larger bronchi and trachea. The latter is suggested by the rather sudden expectoration of more than the usual amount of sputum two or three days after operation. If the temperature has been unduly elevated it may drop quickly following this occurrence. It is likely in such cases that both the reduction in amount of sputum and the elevated temperature are due to ineffective drainage of secretions and special efforts should be directed towards encouraging expectoration as described under post-operative care.

The skin is prepared as for any major surgical procedure. As extensive adhesive strapping is necessary to maintain the large dressing in place, shaving should extend from the spine completely around the side to be operated on, and across the anterior chest wall on the opposite side. This will greatly facilitate the application and removal of adhesive strapping and add to the comfort of the patient. If there is any evidence of skin infection, such as acne with pustules, this must be cleared up before the operation. A deep infection in a large thoracoplasty wound is a serious complication. Daily scrubbing with green soap and heliotherapy or ultra violet radiation will often greatly improve such infected skins. Any oral sepsis should be cleared up, also. A Seiler's mouth-wash is given the night before and morning of operation. Nervous patients receive a sedative the night before operation and on the morning of operation one of the short acting barbiturates, such as evipal gr. 4-6 and a hypodermic injection of pantopon gr. 1/6-1/3 and hyoscine gr. 1/250—1/200, depending on the age and weight one hour before operation. Excessive sedation is avoided because of the danger of undue respiratory depression and interference with the cough reflex.

Post-operative Care

On returning to the ward the patient is usually placed in bed flat on the back or on the operative side. The foot of the bed is raised twelve inches to counteract any tendency to shock and also to facilitate drainage of sputum toward the pharynx during the early post-operative period when the cough reflex may be dulled. The bed is left elevated until the pulse and blood pressure are satisfactory and until the patient is able to cough effectively.

Intravenous fluids are administered to all patients, usually 5 per cent glucose in saline. As a rule the intravenous is started in the operating-room before the operation begins by inserting a needle in the internal saphenous vein at the ankle, and is continued on the patient's return to the ward. Nausea and vomiting frequently follow thoracoplasty whether the operation is done under local or general anesthesia. Patients are encouraged to take as much fluid as possible by mouth as soon as it can be retained. When prolonged, nausea and vomiting are often relieved by a mixture of chloralhydrate and bromide given per rectum or a subcutaneous injection of sodium luminal, gr. 1 or 2. A glass of hot soda water often gives relief by washing swallowed mucous and sputum from the stomach. If, after these measures, nausea and vomiting are still present, all fluids by mouth are withheld and further intravenous fluids given, or six to eight ounces of warm tap water per rectum every three or four hours.

Properly humidified oxygen is administered routinely by nasal catheter at the rate of four to six litres per minute. The catheter must be properly placed so that the tip lies just above the level of the soft palate in the nasopharynx. If it is pushed too far into the pharynx the flow of oxygen will cause gagging and if the tip is not pushed through the nose into the nasopharynx it becomes easily obstructed. The catheter should be removed periodically and cleaned to permit a free flow of oxygen. If there is undue acceleration of the pulse or dyspnea, the oxygen is continued until improvement occurs and then the flow gradually reduced and discontinued.

The nurse should take and record the blood pressure every fifteen minutes for the first hour, every thirty minutes for the next two hours, and every three or four hours for the next twenty-four. The pulse and respiration rate are recorded at the same time. Surgical shock is relatively uncommon following the modern type of thoracoplasty. There is usually no significant drop in blood pressure below the pre-operative level. The pulse rate is usually elevated on the patient's return to the ward, sometimes up to 110 or 120 but fairly quickly falls once the patient is settled in bed. Some patients continue to run a relatively high pulse rate from 90-110 for several days post-operatively without any evidence of shock or other complication. This is more likely to occur if the pre-operative general condition was poor, if respiratory reserve has been restricted by extensive disease, or if excessive mobility of the chest wall follows the rib resection. In the latter case firm strapping of the chest wall with elastoplast may be followed by a slowing of the pulse rate. Reference to the usual pulse rate before operation is useful in considering the significance of a rapid pulse post-operatively. Any tendency for the pulse to remain above 120, or for a progressive fall in blood pressure to occur, should be reported to the surgeon so that the onset of shock may be anticipated and treated early, or hemorrhage in the wound discovered. The latter is uncommon but occasionally a large hematoma may accumulate rapidly if hemostasis during operation has not been adequate. Excessive bleeding may precipitate delayed shock and require immediate transfusion.

The temperature reaction after thoracoplasty is quite variable; some patients show little or no elevation whatever. Usually, however, there is fever up to 100 or 101 for two or three days, gradually settling down to normal by the end of the first post-operative week. In certain patients whose lesions are more active, the immediate post-operative temperature may be considerably higher than this without any complication ensuing. In the early post-operative days an unusually high and prolonged febrile reaction may mean excessive collection of serum or bleeding in the wound, retention of sputum, or spread of the disease. After the initial febrile reaction subsides, a rise in temperature in the later post-operative days suggests the possibility of wound infection, or a spread of disease.

Pain following operation is also quite variable. Considering the extent of the operation, some patients have surprisingly little pain. As a rule, however, dilaudid gr. 1/32 or pantopon gr. 1/6 are required every four to six hours during the first forty-eight hours. After this the interval between injections is increased as much as possible. After the first two or three days aspirin and codeine are often effective in relieving pain sufficiently to limit the need for stronger analgesics. Heavy doses of the opiates should be avoided in order not to unduly depress the cough reflex. If there appears to be excessive pain soon after the patient returns from the operating-room the possibility of hemorrhage in the wound should be suspected.

One of the nurse's most important duties in the post-operative care of a thoracoplasty patient is to see that sputum is effectively evacuated. In general surgery, even when operations are performed on patients with normal lungs, post-operative pulmonary complications, due to the retention of secretions in the bronchial tree, are rather common. The presence of abnormal amounts of secretion in tuberculous patients leads to an increased hazard in this respect. In addition, retention of secretions loaded with tubercle bacilli may lead to an extension of the tuberculosis in either the operated or contralateral lung. Following operation, cough may be much less effective due to mobility of the chest wall. The depth of breathing and cough may also be voluntarily restricted because of pain. In the early post-operative hours the patient should be encouraged to breathe deeply and cough at frequent intervals. The accumulation of secretions in the larger bronchi is readily recognized by a bubbling sound best heard at the open mouth on forced expiration. The effectiveness of cough can be increased and pain reduced if the nurse firmly supports the anterolateral chest wall with the open hand during cough. The patient's position should be changed frequently to encourage ventilation of all parts of the lung, and to assist in raising sputum. He should not lie on the unoperated side for any length of time in the early post-operative period, but turning on this side for a few minutes every three hours often greatly facilitates the raising of sputum. The effective control of pain is important in encouraging efficient coughing. Some patients having thoracoplasty will be known to have bronchial stenosis, discovered by bronchoscopy in the pre-operative period. Forceful, explosive coughing is less effective in raising sputum in the presence of stenosis than gentle coughing or a series of expiratory grunts. Occasionally bronchoscopic aspiration of secretions may be necessary.

A potentially serious complication of thoracoplasty is excessive mobility of the chest wall. This leads to paradoxical movement indicated by retraction of the anterior part of the chest on inspiration and bulging on expiration and cough. If excessive there may develop a severe disturbance of respiration and circulation which accounts for many of the deaths directly due to operation. The ill effects of excessive paradoxical movement usually become evident within two or three days of operation and are indicated by increasing dyspnea, cyanosis, rapid pulse, falling blood pressure, fever, and the expectoration of watery, pink fluid indicative of pulmonary edema. Excessive paradoxical movement can be counteracted by firm elastoplast strapping over a rubber sponge or a cotton pad placed on the anterior chest wall below the clavicle. Effective support can also be obtained by placing the patient on the operative side with a firm pillow or blanket rolled in the axilla. Shot bags may be used on the anterior chest wall but are not as effective as either of the above methods.

If the wound has been drained, the dressing should be changed in twenty-four to thirty-six hours and the tube removed. If no drain has been inserted the first dressing may be delayed until the third day. If, however, there is evidence of any excessive oozing the dressing may become quite uncomfortable and should be changed earlier. If there is any unusual pain or elevation of temperature, the dressing should be removed and the wound examined for any evidence of excessive collection of serum or of infection. A hematoma in the wound is usually quite painful and should be relieved by aspiration. It is useful to have an aspirating set always sterile on the wards so that it is readily available when dressings are being done. The skin sutures are removed in from six to seven days and the wound supported by several strips of flamed adhesive.

Patients are encouraged to move around in bed as soon as possible after operation. After the second or later stages they should spend much of the time lying on the operated side, with a firm pillow or blanket-roll in the lower axillary region and no pillow under the head. This position is useful in counteracting any tendency towards the development of a scoliosis. In the majority of patients there is some tendency for scoliosis to develop due to loss of support of the ribs on the operated side, plus the unopposed pull of muscles on the unoperated side. In adult patients in good physical condition and with attention to posture in the early postoperative weeks, scoliosis may be entirely absent or of a degree insufficient to cause deformity. In children, adolescents, and in adults in poor physical condition, scoliosis is more likely to be pronounced and may occasionally lead to severe and progressive deformity. Lying on the operated side also increases the collapse of the chest wall because of the continuous pressure exerted on generation has occurred. Shot bags of the decostalized portion before bone regraduated weight up to seven or eight pounds are frequently used to increase collapse. They are placed on the anterior chest wall but should not be allowed to rest on the clavicles. Their use is commenced within a day or two of operation and the weight increased as quickly as can be tolerated. Early movement of the arm and shoulder should be encouraged in order to overcome any tendency to limitation of movement as a result of formation of scar tissue in the wound and contracture of muscles. Walking exercise is resumed on the sixth day in preparation for the next stage of operation. Following the final stage, however, most patients are kept on total bed rest from three to six months or longer, depending largely on the preoperative condition and on the effectiveness of operation in closing cavities and rendering the sputum negative.

A Thoracoplasty from a Patient's Point of View

B. M. Evjen

There was a time when I thought I would rather die than have a thoracoplasty. I suppose it was the cosmetic aspect as much as anything that caused this assumption. The idea of pain or suffering never frightened me, knowing that modern science and medicine had ways and means of alleviating pain; plus the fact that I had some experience before in evaluating my own endurance.

However, the ravages of tuberculosis removed all doubt. It was now a case of having a thoracoplasty or maybe dying. And life is sweet! I knew I would rather have a series of operations than die, or perhaps spend the rest of my life in bed.

With the surgeon's approval and renewed confidence, I began to look forward to this entirely new experience. Every one was extremely kind; the surgeon made me feel as if I had to get well just to please him. The doctors and nurses, too, seemed to take such a personal interest so that the very least I could do was to give my wholehearted co-operation. This kind, personal interest was what I appreciated most of all, but I can still remember, too, the air of confidence displayed by those who were attending me. They looked as if they had a "job" to do for me and went about it methodically and efficiently.

Since I had my five stages of thoracoplasty under local anesthetic, I might mention a few of the highlights as I remember them. The first stage could be called the "quiet" stage, because I had lost my voice about six months previously. However, I made a good listener as the surgeon explained each of the various steps during the operation. It helped a great deal for I was able to brace myself for the numerous sensations. For example, the clamping-down feeling when a rib was removed; the burning sensation when formalin was applied to the periosteum, and the somewhat similar feeling when a nerve became too sensitive. My attention was concentrated on the fact that I must lie very quietly. A doctor and nurse were busy applying cold cloths to my head and giving me ice chips to munch. Even then I had to have a rub-down after I got back to the ward on account of perspiring profusely.

The second and third stages were much the same, except that the local anesthesia was not quite as complete and I can remember distinctly the feeling that someone seemed to have his foot right in my pleural cavity, and was stepping down hard. But following the first operation, I had recovered my voice and I could groan a little. The fourth stage, the anterolateral one, was the easiest operation for me. After the surgery had begun, it seemed an interminable age of listening without hearing a thing, or of feeling a thing. Looking up into the nurse's eyes, I asked, "Are they still working on the western front?" There was suddenly a note of restrained laughter in which I joined. It soon dawned on me that this was causing the surgeon difficulty and that his patient must stop laughing. The fifth stage was not as hilarious but the end of my surgery was in sight so it became one filled with hope. After each stage, my symptoms were disappearing, as if by magic. My strength and health were also vastly improved.

From the operations a lot of encouragement comes from feeling so much better but to some who may not feel this immediately, the nurses do much to encourage and cheer. Certainly the difficult hours of trying to use "that stiff old" arm, and the ordeal of getting accustomed to a most uncomfortable brace, are trials that take a bit of patience for staff and patient alike. Just after having a "hypo" is the best time to start using a brace or shot bag. There is then a simultaneous rest of mind and body. As time goes by, the brace becomes an ally, rather than a bug-bear. The shoulder, proving a source of amazement, likes to creep up under the chin. Why it should want to go up, when it has more space below, is difficult to understand. Certainly a nifty little shot bag will help keep it level with its neighbour.

From my personal experience, the nurse who best anticipated my needs was of great help to me. When I was unable to write, she would make some arrangement to keep the folks back home informed of my condition. She would subtly introduce me to some form of handicraft, such as knitting, crocheting or painting (the latter I enjoyed most). This was invaluable in keeping my mind occupied and also in retraining the muscles of my shoulder and arm.

The cosmetic angle, and the wellbeing of the female patient, can be enhanced by consulting a corsettier to get a properly fitted "Bra", as soon as the brace is discarded.

The Scope and Challenge of Tuberculosis Nursing

ESTHER PAULSON

The whole range of tuberculosis nursing has undergone a tremendous change as a result of progressive medical science. In the past, many nurses and others have regarded tuberculosis nursing as a field for the nurse about to be retired or for one who is unable to withstand the routine of the busy wards in a general hospital.

Tuberculosis sanatoria are no longer considered as places where far advanced cases are treated with bed rest for months and sometimes years. Today, through improved case-finding facilities, there is a predominance of minimal cases found. The average length of stay in the sanatorium has been greatly reduced. The introduction of collapse therapy and thoracic surgery has changed the regime of treatment for the tuberculous patient.

Tuberculosis nursing, with its corresponding changes, offers unlimited scope and opportunity for skilled nursing service in its many phases. Staff contributions, through individual members, require co-ordination of thought and effort, and a clear understanding of the entire program of control and prevention of tuberculosis. Only then can the individual appreciate his role in relation to the whole, and accept his responsibility from that standpoint. Tuberculosis nursing is a specialized field which demands well-trained and interested nurses. They must be objective, able to co-ordinate their services with that of many other workers in allied fields. They need a sound knowledge of the disease in its many aspects, and skill in technical and infectious technique and bedside care. In addition, an understanding of the principles of mental hygiene and practical psychology is essential in dealing with the many problems associated with this long-term disease. The public health outlook and ability to teach are other musts for the nurse, be she a general staff nurse on the wards, in the clinics or in a district of the community.

Teaching is not confined to the public health nurse and the clinic nurses. Bedside care is not the sole function of the staff nurse on the ward. A comprehensive plan of care for the tuberculous patient does not permit the separation of duties into different categories. All must share in these basic functions of physical care and preventive teaching.

The public health nurse must know the fundamentals of good bedside care and infectious technique as practised in tuberculosis nursing in order to be useful to the newly-diagnosed case on home treatment pending admission to the sanatorium and to the other bed cases in the community. She must be aware of all the incidental points concerning diet, exercise, rest, recreational and occupational activities. The ward nurse, in addition to her skilled bedside care, must be prepared to meet the complex needs of the tuberculous patient, including teaching him what he must know about his disease in order to take care of himself intelligently and to avoid spreading the disease to others. The sanatorium provides the ideal opportunity for a consistent program of education and supervision. If the bedside nurse fails to appreciate the importance of adequate and effective teaching, that patient is returned to the community untrained, unco-operative and careless — a menace to the community and a hopeless problem to the public health nurse. On the other hand, the public health nurse who forgets to prepare the new patient for hospitalization, to observe and detect in his attitude, or that of the relatives, any signs of antagonism, fear, bravado, hopelessness, or other symptoms of maladjustment, sends to the sanatorium a patient who will be difficult and possibly unwilling to accept treatment and separation from his family and past associations.

These references indicate the degree of inter-relationship and dual responsibility for the control and prevention of tuberculosis which must exist between the sanatorium staffs and those of the district public health agencies.

In the Vancouver Unit an attempt has been made to bridge the gap between the time the patient leaves his home until he is ready to be returned to it from the sanatorium. Too often this period is a closed book to the public health nurse. A work sheet has been prepared in co-operation with the director of public health nursing for the Vancouver Metropolitan Health Board and the provincial public health nurse consultant. The head nurse records information concerning the patient during his stay in the sanatorium. Headings cover the following points:

1. Patient's attitude toward his disease, isolation precautions, relationships toward staff and other patients, family.
2. Interest or the lack of it in the teaching program, the degree of co-operation in maintaining isolation precautions and exercise orders.
3. Interest and participation in occupational therapy, educational courses.
4. Exercise grade and date of next chest x-ray on order of doctor-in-charge.

The form is then sent to the out-patient clinic where the nurse-in-charge records the date of chest x-ray appointment and information concerning pneumothorax — frequency and date of next appointment.

The social worker adds a brief record of her contact with the patient and any social problem or tentative plans. The information from this form is transferred to the "Summary on Discharge" and sent to the public health nurse who will continue supervision of the patient.

The patients are interviewed by the nurse in charge of the clinic prior to discharge in order to establish a friendly contact for future visits to the clinic. She also sends on any pertinent information to the public health nurse pending the arrival of the "Summary on Discharge" and other records.

Nursing service within the sanatorium presents a tremendous challenge, dealing as it does with so many aspects: the patient's physical care, intensive and incidental teaching, supervision of isolation precautions, detection of psychological and social problems, and stimulating and maintaining morale and determination to stay "on the cure" until, in the doctor's opinion, it is time to start thinking about a return to normal life and competition with well people.

The patient with a long-term disease is faced with many problems of grave social consequence which require skilled and sympathetic understanding from the nurses, who, after all, are in more constant attendance than any of the other workers serving the tuberculous patient. Indications of unrest, discontent, worry, defiance, criticism of food and the institution in general, and other behaviour problems, all have a basis, a very real reason, and the cause of such behaviour must be discovered. The nurse "is on the spot" to notice such signs in their early stages. While she is constantly dealing with such problems in an incidental way, some may require the intensive work and the scientific approach of the medical social worker. A sound and thorough understanding of the functions of the allied workers is essential if the patient is to benefit from the many resources which exist to meet his needs and help him to regain his health. The patient is not a case belonging exclusively to the doctor, the nurse, and the social worker. He is an individual in need of assistance and help from any one of the services and workers according to his needs. The same is true of the teacher, occupational therapist, librarian, or dietitian, all of whom are there for the benefit of the patient — another reason for every worker to understand his role in relation to the whole program of control and prevention of the disease.

Definite effort and planning is necessary to foster such unity of thought, purpose and effort. The most effective channel is through staff education and orientation of new staff members. Education in the sanatorium must begin with the staff members and include all sections if it is to be an effective weapon in the control and prevention of the disease.

In the Vancouver Unit regular staff meetings are held and an orientation plan for new staff members has been established. A representative committee has been formed to review the magazines and journals, summarizing briefly any informative and interesting articles.

General staff meetings are held about once a month, attended by nurses from the wards, out-patient clinics and x-ray department, social workers, and other allied workers as dietitian, occupational therapist, teacher. The meetings are held at 1:15 to 2:15 p.m. to coincide with the rest hour. These meetings present opportunities to improve working relations among the various departments through free discussion of problems, the interpretation of new policies and discussion of procedures and ward routines to establish uniformity of standards. Lectures to the graduate staff by specialist consultants have also been given. A written account is prepared of each meeting and circulated to all departments for the information of those unable to attend. Separate staff meetings are held at less frequent intervals with the housekeeping and assistant staffs, including the nurse aides and ward assistants, orderlies and cleaners.

New staff members, including nurses, nurse aides and ward assistants, orderlies, and cleaners are given an orientation program during the first two days after which they are assigned to duty under supervision. Policies and general information have been compiled in handbooks, one for the nursing staff and one for the assistant staff and are thoroughly reviewed during the orientation period.

Education of the patients would be inadequate and inconsistent without an interested and informed staff to set and maintain a standard of efficient service throughout the institution.

The educational program for the patients is underway but is still open to revision in order to establish a method that will ensure a consistent teaching plan to all new admissions and adequate instruction and review of material to meet their needs later on. At present one nurse on each ward is assigned for one month to carry out the teaching of the new patients. In order to combine the teaching with the routine work the daily care of the new patients is assigned to this nurse thereby covering many of the teaching points during the giving of a bed bath or morning and afternoon care.

A teaching guide to assist the nurses has been prepared by the student supervisor. A definite outline of points to be taught and sub-headings covering the details is included in this outline. A teaching record is kept on each patient's chart. This record contains the headings of the teaching points which are checked off and the date noted as each is completed. A section is reserved for notations as to the patient's attitude, degree of interest and his application of the knowledge. Serious problem cases are referred to the medical social worker. The nurse, alert to her responsibilities, cannot be disinterested in the teaching program. Ingenuity, diplomacy, tact and patience are required as well as teaching ability in order to adapt the material to suit the individual patient, within the limitations of his intelligence

In the June, 1945, issue of *The Canadian Nurse*, the affiliation course in tuberculosis for student nurses as given at the Vancouver Unit was described. This is an added challenge to the graduate nurses on the staff who set the standard of service in the institution. They represent the ultimate goal of every student nurse and it is their responsibility to set the example and maintain a high degree of efficiency at all times. The same is true of the housekeeping and assistant staffs. Sound knowledge of isolation technique and rigid adherence to the routine of the institution is essential.

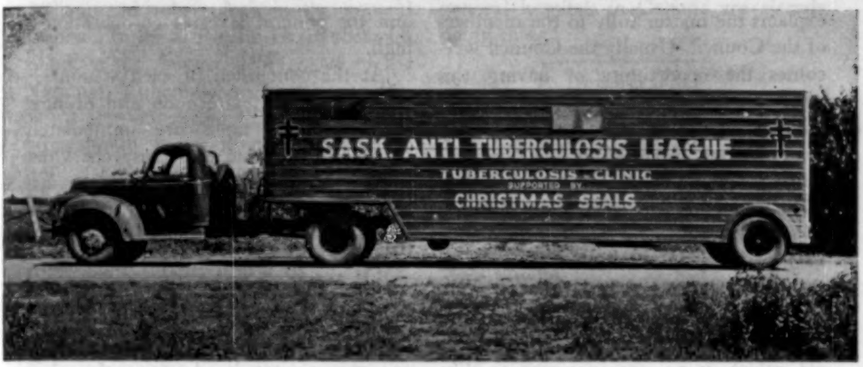
In conclusion, it is hoped that the present developments and future potentialities of tuberculosis nursing may place this field of nursing in its proper perspective. In these days of changing emphasis, new developments and trends, tuberculosis nursing offers a challenge to the best of our young Canadian nurses who should find in this phase of nursing plenty of scope for initiative and opportunities for growth and promotion comparable to any other branch of nursing. The general staff nurse in a tuberculosis sanatorium, alert to the problems and the resources to deal with them, is giving a service which cannot fail to bring satisfaction and incentive for further interest and effort as her part in the control and prevention of tuberculosis.

Fluorographic Surveys and Prevention of Tuberculosis in Saskatchewan

GRACE GILES

Under the double-barred cross of "Lorraine", the Saskatchewan tuberculosis crusade really began in 1911, when an Anti-Tuberculosis League was formed and an active campaign against the disease was commenced. The first sanatorium was opened at Fort Qu'Appelle in 1917 and some years later sanatoria were built at Saskatoon and Prince Albert. There are now 765 beds for the treatment of tuberculosis in Saskatchewan, compared with about 11,000 for all of Canada. In the preceding articles one aspect of the work being done in this province has been described. Along with provision for the most modern forms of treatment the Anti-Tuberculosis League is constantly promoting the techniques of prevention.

In October, 1941, the town of Melville, Saskatchewan, made tuberculosis history as the first district in Canada to be the scene of a community-wide fluorographic survey. Since then the extent of this work has greatly increased. During 1944 some 125,568 persons were examined in this way. Of 121,847 persons who were representative of the entire communities examined, the frequency of new active cases was 0.865 per thousand, compared with 0.93 per thousand among the 82,135 persons examined in similar surveys in 1943 and with 1.34 per thousand in 1942. In a survey of 48,709 persons in the city of Regina, made between April 17 and May 12, 1944, 32 new active cases of tuberculosis were found. Twenty-one of these were in need of treatment and were admitted to sanatoria. The advan-



Saskatchewan Anti-Tuberculosis mobile clinic.

tage of such discoveries to the community, as well as to individuals, is self-evident.

It may be of interest to compare the rate of new active cases discovered in Saskatchewan mass surveys with results, following a similar method of investigation inaugurated in the Royal Navy in 1939. In a representative sample the number of active cases found requiring treatment was four per thousand. The great value in these surveys, of course, is the discovery of early cases before they have positive sputa. While most patients with tuberculosis are referred to the sanatoria by private physicians, the difficulty is that many persons do not seek medical advice soon enough. The superiority of mass x-ray survey is shown in a report of such a survey of a district in Chicago in 1940, where 50 per cent minimal cases were found, as against 15 or 20 per cent minimal cases found in the old-time routine clinic examinations.

An excellent technique of mass survey has been developed in Saskatchewan and a short account may be of interest to nurses in other parts of Canada to compare with the preventive measures with which they are familiar. The plan for the surveys is to cover the population by geographical area, doing districts with the highest tuberculosis morbidity and mortality rates first. In 1945, three complete fluorographic units were in operation. The illustration shows the newest unit to be acquired by the League. It consists of a two-and-one-half ton truck, self-contained van and a generator. The floor space of the examining room is roughly fourteen feet by eight feet; there is also a built-in dark room. "By placing a canopy from the trailer to an adjoining building the unit can utilize small halls or buildings for dressing rooms and have the essential equipment in a compact unit in the trailer. The first week this arrangement was in operation a total of 1,290 persons examined in one day was attained."[1] Comparable numbers have on occasion been achieved even with less satisfactory equipment. The working team for each unit consists primarily of a doctor and four x-ray technicians. Sometimes there is a steno-clerk and recently it has been possible to have a public health nurse. With voluntary aid, which changes from session to session, the working staff is about seventeen people.

Before a fluorographic unit can commence work in any district a very considerable amount of organization and co-operative effort is required. Each survey is arranged through the co-operation of a municipality. The organizing secretary from the League's head office explains the matter fully to the members of the Council. Usually the Council welcomes the opportunity of having this service provided to its constituents and willingly plans to carry out the necessary organization. A meeting of representative people of the community is called. Teachers, clergymen, farmers, business men, doctors and, of course, the public health nurse, are all needed to share in the project. At this meeting arrangements are made for a suitable time and place and for the necessary volunteer aid which is so very important. The volunteers help to get the idea across to the community because, as well as the regular channels for informing the public, there is need for house-to-house canvassing. Although Saskatchewan people are most co-operative, the canvassers, as well as being armed with "request cards", also take along a supply of reasons why it is wise to be x-rayed whether one thinks he has tuberculosis or not. Occasionally they are met with such remarks as, "I don't believe in this sort of thing. The Lord never meant us to go interfering in His ways," or, "It's just an election dodge put on by the politicians, because they think it will get them votes." Certain points which the canvassers stress are: no person is too old to be x-rayed; the examination is free; privacy is afforded by separate dressing rooms for men and women; paper capes for the women are furnished in the dressing room; x-ray reports are confidential and are kept on file at the sanatorium. The x-ray reports, by the way, are confidential between the survey physician and the patient's physician.

The public health nurse, with her knowledge of the community, is a valuable assistant in bringing in "the doubters" and in assisting with any special problems while the survey is in progress. Volunteer aides help with the general organization for handling such large numbers of people in a short time. Councillors sometimes vie with one another for the highest percentage of attendance, and the general level of co-operation is high.

At the conclusion of each session — that is morning, afternoon and evening — the fluorographs are immediately developed and read. Any suspects which may come out of the interpretation are sent for so that they may be looked after while the x-ray facilities and doctor are still in the community. The "recalls" have standard x-rays taken, are tuberculin tested, have a history taken and an examination made. If for any reason this cannot be done at the time, other arrangements are made for the recall. Should it be found that the patient requires sanatorium care this is free to the individual, the money being provided through the Free Treatment of Tuberculosis and supplied by the League at its sanatoria.

To conduct an efficient and effective program of prevention money is obtained by donations to the Christmas Seal Fund, and contributions are raised by the Associated Canadian Travellers, radio appeals, Rural Municipal Secretaries Fund, clubs and schools. The Christmas Seal contribution amounted to $90,328.87 in 1944. This is concrete evidence that Saskatchewan citizens believe that "prevention is better than cure." There appears to be good reason for this belief. The costs of illness alone, in the case discovered late, are about three times as high as for an early minimal case and this makes no allowance for the time the patient is unable to earn and the greater difficulty in securing suitable employment later.

No reference has been made in this account to preventive work among student nurses. Dr. R. G. Ferguson, director of medical services and general superintendent of the Anti-Tuberculosis League, reported on work carried out in the vaccination of student nurses with B.C.G. in the January, 1945, issue of *The Canadian Nurse*. It is pretty generally agreed that probably the greatest hazard for nurses is the patient with undiagnosed tuberculosis in the general hospital. In an article by Dr. Robert G. Block in the August, 1944, issue of the National Tuberculosis Association Bulletin,[2] it is suggested that fluorographic film should make it possible to have routine x-ray examination of all patients admitted to general hospitals. This suggestion seems to have a good deal of merit for the patient as well as the nurse. It would be interesting to know if any general hospitals in Canada are already doing this.

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The Professional Status of Nursing

Genevieve Knight Bixler *and* Roy White Bixler

It is the intent of the writers to appraise the status of nursing as a profession and in so doing to indicate some types of development which would improve the professional standing of nursing. The project has been undertaken with full appreciation of the progress nursing has made in the relatively brief period since the establishment of the first Nightingale schools in America and with the hope of stimulating an accelerated tempo of growth toward professional maturity. In the consideration of nursing as a profession, criteria generally accepted as applicable to professions will be used.

The term *profession* is used more broadly by some than by others. The U. S. Bureau of the Census lists twenty-one categories of professional workers, including such persons as actors, musicians, and artists, along with physicians, lawyers, clergymen, engineers, teachers, and nurses. Those included in the first group appear to be different in type from those in the second group of more commonly recognized professional persons. The difference lies in the principal objective and the body of knowledge upon which the practice rests. The practice of artists, musicians, and actors is an application of highly specialized technics of expression which yield satisfactions chiefly through emotional outlets, though the work of these professional groups may be utilized to achieve social objectives. The more commonly recognized professions appear to consist of those having service to man and society as the primary objective, though this is not to deny that emotional satisfactions are derived, also, from the practice of these professions. Thus, it appears that there are fundamental differences between the professions related to the fine arts and those dependent upon philosophy and science. For the purpose of this paper it is, therefore, appropriate to limit consideration to the type of profession to which nursing belongs, and the criteria which are applicable to this group. These criteria have been variously expressed by different writers, but there is general agreement on their essential points, though emphases differ from time to time and from profession to profession.

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It is generally agreed that *a profession utilizes in its practice a well defined and well organized body of specialized knowledge which is on the intellectual level of the higher learning.*

To relate this first criterion to nursing, one may refer to the *Curriculum Guide** for the best formulated statement of the now recognized definition and organization of the body of knowledge utilized in the practice of nursing. Although this book was published almost a decade ago, it represents, even now, an advanced position with relation to the rank and file of nursing schools throughout the country.

One fundamental question must be raised about the field of knowledge. It relates to the lack of a well defined and well organized nursing science. There is much medical science, and the biological and physical sciences are well represented, but there is no nursing science as such. The nursing science is largely concealed in the nursing and allied arts.

The early emphasis of nursing as an art is to a large extent the concept still held. This is borne out by the terminology and by the disproportionate time spent in teaching young women the *how* as compared to the time spent teaching the *why* of nursing procedures. John Stuart Mill said that an art consists of the truths of science arranged in the most convenient order for practice instead of in the most convenient order for thought. If the practice of nursing is not to become a static art, its underlying science must be arranged in the most convenient order for thought.

The elements of science underlying nursing should be speedily defined and organized as nursing science. These elements should be gathered from every science now recognized as contributing to nursing, and fields not at present known to be specifically related to nursing should also be explored. The job should be done by nurse scientists and educators, who know better than any other persons what science is related to nursing, with assistance, of course, from specialists in other fields.

It is discouraging to realize how slow progress has been toward this ultimate objective, but it is heartening to discover, by a diligent search of the literature, that several nursing leaders are aware of the need of an organized nursing science, something as uniquely the possession of nursing and the basis of the practice of nursing, as medical science is of the medical profession.

The organization of a nursing science would not rule out the use of allied sciences, for there would still be a scientific approach to nursing in which the sciences used would not be professionalized, i.e., specifically applied in the practice. Some of medical science, and of the biological and physical sciences would be used in this way. Nor would it rule out nursing art. Rather it would require a fusion of nursing science and art, with emphasis on the science.

It should be remembered that the compartmentalization of science, so generally used, is an arbitrary and artificial scheme devised for convenient handling of the sciences. There is growing need for synthesis as evidenced by the appearance of such fields as physical chemistry, physiological chemistry, biochemistry, and geophysics. The development of a nursing science would not be another step in compartmentalization, but rather an identification and application of scientific principles, wherever found, to a specialized field of professional practice—truly a new synthesis.

Nursing, though now some distance away from professional status in this respect, can improve its own position among the professions and render a marked service to its individual members and to society through the development of its own integrated professional science. When the nursing textbooks in the clinical fields, now written by doctors with nurses collaborating, are replaced by texts written by nurses, or by nurses with doctors collaborating, it will be evidence of significant progress in the establishment of a nursing science.

**A Curriculum Guide for Schools of Nursing* National League of Nursing Education, New York, 1937, p. 689.

The second criterion is a logical outgrowth of the first. *A profession constantly enlarges the body of knowledge it uses, and improves its technics of education and service by the use of the scientific method.*

This will be readily identified as the research function of a profession. It is the device employed to provide for continuous growth in competence of the profession and of its members to serve man and society in the approved way. Without a program of research, a profession would eventually become static—occupied with practices which are no longer in harmony with the latest scientific development and newer philosophical thought. A *profession* without a research program is actually not a profession at all.

Some nursing leaders are aware of the limitations in nursing in this fundamental respect. Even these clear-sighted persons have as yet been unable to overcome the obstacles to the adoption of the training essential to a long-time, comprehensive, self-perpetuating program in nursing research. It is true that many "studies" have been made. There is a self-consciousness about the avoidance of the term, *research,* which shows an awareness of the limited scientific method used in much of the exploration thus undertaken. Until institutions of higher education have developed programs and produced numerous nurse scientists of demonstrated research ability, nursing will be unequipped to carry forward research on a scale comparable to that of kindred professions. Untrained people cannot do research, nor can they teach and stimulate others to do research.

There is no virtue in having a doctor's degree beyond the knowledge its attainment has brought and the skill in applying the scientific method which practice has perfected. To say that nursing as a profession can get along with less specialized preparation for some of its most needed functions is, in effect, to say that research need not underlie nursing progress, or that nurses can do research without special preparation, neither of which is the case. It may be that nursing has not been attractive thus far to women who could become interested in and competent to profit by the long educational program leading to this objective. It may be that remuneration for such an expensive preparation has seemed too uncertain. Whatever the reasons for this dearth, nursing should be able to overcome them and to attract numbers of promising young women who, in the course of several years, will be prepared to give service of a high order. It is not being said that there is now no research in nursing, nor that nursing has no persons competent to conduct research, but rather that the profession does not now support a thoroughgoing research program, and that no university in the country is seriously committed to the preparation for nursing research of a sufficiently high order.

It will be noted by the careful reader that the conduct of research in nursing is being advocated as the duty of nurse scientists. Until a sufficiently large supply of nurses of this caliber is available, nursing must depend upon researchers from other professions. As a temporary policy, this is not to be condemned, because the methods of research are universal, and skilful persons in allied fields, with some assistance from nurses, can comprehend the problems peculiar to nursing. Furthermore, nurse collaboration with workers from allied fields, especially if young and promising women are utilized for this purpose, can have high training value for those who participate. The current practice of depending, for professional nursing counsel in such studies, almost exclusively upon the older members of the profession who are greatly limited in the contributions they can make, because of the heavy responsibilities of their positions, is unproductive, because it does not increase the number of skilled researchers in nursing.

Teachers of nursing, along with teachers and administrators of research, must accept the responsibility for development of competence in research. Teaching and research go hand in hand in the professions. Those who instruct must develop the scientific attitude in students. Under their stimulation and supervision, students can begin some elementary research, singly and in groups. The classroom can become a seminar for the testing of hypotheses and conclusions. In institutions where democracy prevails, staff members can also be stimulated by eager students, and required to defend their own work.

From certain points of view, the way a profession plans for the education of its members is the most crucial thing about its over-all program, for here is the process which changes the neophyte into the skilled and thinking practitioner. This introduces the third criterion which indicates that *a profession entrusts the education of its practitioners to institutions of higher education.*

Professional schools are commonly associated integrally with universities. Their chief administrative officers are co-ordinate in rank and responsibility with such officers in other divisions of the academic association. The instructors of such schools are similarly comparable in rank, salary, professional prestige, and standing in the community with those of the colleges of arts and science. How does nursing meet this criterion? More than any other single factor, the low level of educational preparation prevents nursing today from being a real profession. A fearfully large proportion of those becoming nurses are in programs of study which occupy them through three calendar years of time spent chiefly in the care of ill persons. It is unnecessary to present more details of a picture nurses know so well, but the point must be strongly made that so long as such preparation continues to represent the typical in nursing, the educational end product will be at a disadvantage in the family of professional workers. One might condone the continuation of such preparation of nurses through the period of national emergency on the basis of the staggering needs of military and civilian service, if one could be certain that upgrading would be only temporarily interrupted thereby.

There is a growing realization of the need in nursing to differentiate professional nurses from the workers whose duties are less highly specialized. This is an inevitable part of the evolution of nursing toward full professional status. A parallel development is the assumption by professional nursing of increasingly more responsible duties which require new, and more highly specialized preparation. As this evolution progresses, the need for higher education of nurses will become increasingly urgent.

This objective will not be reached, however, in the very near future, for there are many vested interests which must be satisfied. Too rapid development toward the preparation of professional nurses exclusively by higher education could jeopardize the nursing care of patients in hospitals. It will take time for hospitals to adjust to the loss of student nursing hours which will inevitably come when student service is performed for educational purposes only.

The profession should be alert to another danger of too rapid upgrading. That is the tendency for the more advanced education to be designed to prepare only for the higher posts in the profession. There is already a trend in that direction. Advanced training is offered for teaching, supervision, and administration, public health nursing, and the specialisms, but not for general staff nursing. Is general staff nursing to be left behind in the professional evolution of nursing? Some thoughtful nurses seem to think so. That would be an unfortunate development from the point of view of nursing as a profession. Because of the many obstacles rooted in traditional conceptions of nursing in hospitals, it will be more difficult and will take longer to cultivate a professional conception of general staff nursing. The principle cannot be emphasized too strongly, however, that differentiation of education to serve the needs of the specialisms in nursing should be in kind, not in quality. The differentiation for public health nursing, for example, should be in the curriculum content rather than in the quality or level of instruction.

Nursing constantly demonstrates its professional worth in the fulfilment of the fourth criterion which states that *a profession applies its body of knowledge in practical services which are vital to human and social welfare.*

Much of the credit for the amelioration of conditions under which ill and deranged persons have suffered in the years since the Crimean War must be accorded to nurses for the skill, industry, and compassion with which they have cared for those in their charge, and for their persistence and determination in bringing about such a remarkable change in the conception of the social function of nursing.

The expanded national health program which many people hope for at war's end can open to professional nurses such new opportunities and responsibilities as were not imagined fifty years ago. Nurses should be enthusiastic and ready instead of apprehensive and reluctant, as many nurses are today, to have their profession discharge its full responsibility in this forward-looking movement.

One of the tests nursing must be prepared to meet is that of adopting a social attitude, as individuals, and as a profession, toward the emerging conception that every citizen is entitled to adequate health care, just as he is entitled to education, and that the welfare of the nation is contingent on the implementation of that idea. Will professional nursing courageously and vigorously take a stand upon some of the vital health issues of the present and immediate future?

The fifth criterion says that *a profession functions autonomously in the formulation of professional policy and in the control of professional activity thereby.*

The new nursing began in this country, after 1873, with a degree of autonomy which it was not long able to preserve. Independence did not survive the coupling of nursing education and nursing service in the hospital schools, and probably will not be regained until full control of professional nursing passes over to the universities. Even in such an academic environment as the university, the school of nursing is sometimes not favored with complete autonomy. One is familiar with nursing schools which are divisions of medical schools or of schools of education, or even of colleges of liberal arts. Nursing educators must search thoroughly for the underlying factors which limit the progress of nursing schools under such circumstances and then endeavor through the powers of logic and statesmanship, to convince university administrators of the soundness of an autonomous position in the university. It will be a critical test of nursing, after such a position has been achieved, to justify it in the varied intra-institutional relationships, and through an improved product of the nursing school. Here nursing will be challenged by leaders in other professions and assailed by the prejudices which afflict women's occupational groups.

Success in meeting this test will depend on the quality of leadership which nursing can produce from its own ranks. At present nursing has no well-conceived program, designed to identify and prepare a continuous supply of leaders. The early schools, perhaps because of the youthful outlook of nursing at that time, and the challenge of an uncharted future, produced a group of highly intelligent, courageous, and foresighted young leaders, who early assumed and held positions of great influence, carrying nursing through the critical organizing years between 1893 and 1913. In recent years it appears that there has been a lessening of whatever influences were at work in the production of leadership. Today there is found an unwholesome attitude in some of the younger nurses who have been frustrated in their attempts to move into leadership relations in nursing, and who are seeking other vocational outlets for their considerable abilities. It is ineffectual and inefficient to a high degree for nursing to prepare competent persons and then fail to utilize their competence completely.

The profession should definitely plan for the discovery of promising leaders and persistently cultivate their capabilities. At every turn these young women should be stimulated to develop judgment and resourcefulness and to press for responsibilities in some chosen area of nursing in line with their special interests and aptitudes. Then they should be rewarded by appointments to challenging positions. They should early begin to sit in the councils of the leaders and to feel themselves an integral part of the deliberations, instead of being kept on the sidelines where they can participate only as spectators. Their young energies should be absorbed by having to function in complex situations in which they would have the maturing experience of making decisions and then having to take the consequences of these decisions.

Nursing is far from the goal of autonomy. The obstacles to be overcome are grounded in traditional conceptions which are quite contrary to the ideal of independent nursing. It is a goal which nursing can reach only if it can muster all of its strength and move forward on a united front. There is not the unity in the profession at present to move in this way on any issue. Several organizational dichotomies breed jealousies and rivalries that interfere with such action. There are, for example, professional and nonprofessional nurses, nurses and public health nurses, collegiate and hospital schools, Catholic and non-Catholic schools, nursing service and nursing education, white and Negro nurses. It is not the existence of these categories of nurses and nursing that dissipates the strength of nursing but the fact that they have tended to develop as entities within the profession as a whole. There is need for reintegration of all of these forces, through organization, to eliminate duplicating and overlapping professional activity.

Separate organizations within a profession are justified on the basis of differentiation of function. As specialisms develop, it is inevitable that their practitioners will feel the need of association, and there are high values in such groupings. Public health nursing, for example, is sufficiently specialized to warrant an organization of public health nurses within the profession as a whole. Nursing education is a similar example and there can be other natural associations of those who have common specialized interests and objectives. But all such associations should be united as one profession by an over-all organization with inclusive objectives.

This is a problem that should be promptly attacked by nursing. Separate organizations should be limited to those that can be justified on the basis of differentiation of function, and these should be integrated through an organization of organizations—a common device in social engineering.

The sixth criterion characterizes professional personnel. ***A profession attracts individuals of intellectual and personal qualities who exalt service above personal gain and who recognize their chosen occupation as a life work.***

In assessing the standing of nursing with respect to this criterion it is well to point out at the beginning that nursing is subject to the limitation which plagues all of women's work, namely, that the highest priority is assigned to matrimony. Society is largely responsible for the situation which permitted women to enter professional life two or three generations ago, but expects them to withdraw from it after marriage. Although some professions, notably medicine, are more liberal in this respect, favoring continuing practice after marriage of the smaller number of women they accept, in general marriage is a disqualifying factor. Nursing is even less liberal than other professions in this respect. Not only is marriage with its attendant responsibilities regarded as a deterrent to continuing practice, it is fatal to continuation as a nursing student in many schools in the country. It is to be hoped that the return of many married nurses to active nursing because of present shortages of personnel, and the generally good service they have given may help to break down this prejudice within nursing and within the social environment. There is general agreement that society loses on its investment when a well-prepared practitioner is disqualified before she has had time to make any significant return for her education.

It is very difficult to appraise the in- ses. There is not sufficient objective tellectual and personal qualities of nur- evidence to warrant any definite conclusions. What can be said must be based largely on general observation. It will probably be agreed that nurses, level by level, compare favorably with women in the teaching profession. There is some evidence that students of nursing in the best schools compare favorably with students on the same level in the better colleges and universities, but such a large proportion of the nursing schools are inferior in terms of standards the profession is trying to establish, that the general average of nurses probably does not hold up very well. There is some evidence that the ability of nursing students is lower than that of college freshmen. One heartening thing can be said. The situation is not static. The requirements for entrance to nursing are being improved rapidly. Perhaps the more realistic appraisal would be based on what the situation is becoming rather than on what it is now.

Nursing should consciously undertake to build up its level by offering inducements in the way of stimulating programs of study in the better universities, in which young women are offered social opportunities equal to those of anyone on the campus. The challenge of early activity in helping to meet society's demands can be presented in as appealing a manner to well-endowed young women as to less privileged ones but the approach must be very different. It must be demonstrated that there is work to do which will require the resourcefulness of able people rather than a succession of routine activities which one learns to perform without knowing or caring why one does them in certain ways.

There is some evidence that during the war years nursing has widened its appeal to attract more gifted young women. If these can be held and this gain strengthened it will be fortunate for nursing in the years ahead.

Because of the sacrifices professional workers make in exalting service over personal gain, *a profession strives to compensate its practitioners by providing freedom of action, opportunity for continuous professional growth, and economic security.*

The idealistic character of this seventh criterion should be noted. It states that a profession "strives to compensate." There are no professions which have succeeded completely in reaching this objective. Furthermore, it should be recognized that the objective itself is a reflection of inadequate public appreciation of the services professional persons provide. Professions are attempting to repair this defection on the part of society in the compensating services which they undertake to supply.

The sacrifices nurses make because of the nature of their calling are numerous. The hours they spend at work are longer and more inflexible than those spent in most of the other professions. The duties are arduous, and include some extremely distasteful services. Nurses are expected to be detached, impersonal, and calm in all types of situations, even in those which are emotionally disturbing. After spending working hours among morbid conditions many nurses must utilize living quarters within the same institutional walls, a situation which imposes a psychological regimentation even though they are fortunate enough not to have an actual surveillance of their leisure activities.

A degree of subservience not characteristic of other professions is expected of nurses. This is carried to an extreme in the opposition to the advanced education of nurses for fear they will no longer be willing to do menial work. The concept of the nurse as one "who merely takes orders and executes them with meticulous care" is too prevalent, not only among the lay constituency, but also in the minds of many of the nurse's professional co-workers. Reference has been made previously to the frustration of many young nurses because they are given no opportunity to break into the councils of those who direct the destiny of nursing.

It seems doubtful that organized nursing is fully aware of the need to overcome subservience. Some leaders, particularly among nursing educators, are working toward a more democratic educational process, but in order to meet the seventh criterion there must be an awareness and a constructive program on the part of the entire profession, to provide for nurses the conditions which generate a sense of freedom.

Opportunities for continuing professional growth are becoming more numerous in educational centers about the country, but there is not yet a well established pattern of in-service stimulation sufficient to keep practicing nurses moving in and out of classrooms, libraries, and laboratories and participating in conferences and workshops. If graduate nurses were more aggressive in demanding such stimulation the few offerings now available would be increased, the quality of courses would be improved, and the means to afford such refreshment would be more generally provided by scholarships, salary increases, and extended leaves with pay. In this, as in much else of an ameliorative nature, changes come about if the demand for them is sufficiently active.

The income of the nurse, if her maintenance is included, compares favorably with the income of teachers, but neither is a satisfactory living wage if the proper care of health, recreation, good housing, and continuous self-improvement are regarded as legitimate components of living.

Organized nursing is aware of most of the unsatisfactory conditions related to the service of the nurse. Good work has been done in sponsoring and advancing movements of benefit to nursing such as the adoption of the eight-hour day as a standard, better salaries, vacations with pay, insurance to cover accident and sickness, and plans for retirement income. There is need for strengthening such services. Nothing is at present available to nurses which is equivalent in coverage and soundness of conception and organization to the services to teachers in the form of insurance and provisions for retirement income.

Evidently the profession has some distance to go before it can be said that nurses have the environmental conditions essential to full self-realization.

SUMMARY OF IMPLICATIONS FOR NURSING

In spite of the weaknesses pointed out in the foregoing appraisal, nursing stands up well. It should be recognized that if these criteria were applied to other professions their weaknesses would be exposed also. The limitations have been emphasized because that is necessary for constructive purposes. In the summary which follows, the types of development which are indicated as most needed in order to advance nursing to the status of a mature profession are compactly presented.

The field of knowledge basic to the practice of nursing is well defined and well organized with one exception, that which relates to the sciences. It would strengthen nursing to have a recognized science of its own. It is proposed that all of the science which is directly applied to nursing practice be defined and designated as *nursing science*, and that it be integrated with nursing art.

Nursing needs to establish the function of research to extend and disseminate its field of knowledge, especially in the areas of nursing science and art, the teaching of nursing, and administration. This will require a considerable development in graduate nursing education on the level of the doctorate.

Nursing should extend and accelerate the present movement toward the organization of collegiate schools, in order to advance the education of nurses to the level of the education of practitioners in the other professions.

The social value of nursing ranks high among the professional services, and opportunity for services of still higher value are emerging in the inevitable broadening of socialized public health services. Nursing should grasp this opportunity to increase the social value of nursing service by taking a firm and positive stand upon this issue.

The effort to achieve autonomy should be continued with as much vigor as the profession can muster, and with a quality of statesmanship befitting a profession. Emphasis should be concentrated on the improvement of group consciousness and solidarity through self-organization and co-operative activity, professional determination of standards of nursing education and service on all levels, professional control in accordance with the standards adopted, and a positive program for development of leaders from within the ranks.

With the exception of the limitation women's professions have, in their tendency to assign matrimony a higher priority than a professional career, nursing compares favorably with kindred professions in the quality of the individuals it attracts. The profession should be highly sensitive, however, to the need for upgrading the quality of its practitioners, especially in view of the opportunity for services of higher social value that lies just ahead.

The profession should adopt high ideals of freedom of action and provide opportunities for professional growth and economic security for its practitioners. It should not be satisfied with any degree of achievement less than that necessary for individual self-realization on a high level.

Preview

Lillian Thomson, whose interesting comparison on the work of public health nurses and social workers appears currently, has prepared a valuable commentary on the Technique of Interviewing which will appear next month on the Public Health Nursing Page. Few public health nurses start their work possessing this essential skill. While it is developing, these useful tips will help to smooth out some of the more obvious difficulties.

Interesting People

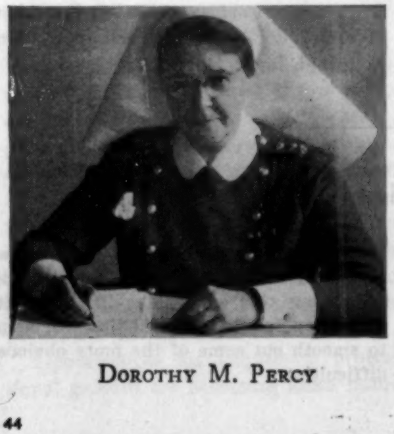
Dorothy May Percy, who served for four years with the R.C.A.M.C., the last thirteen months of which she was matron of the Petawawa Military Hospital, has recently been appointed executive secretary of the Division on Health with the Welfare Council, Toronto. The Welfare Council is the planning body of the United Welfare Chest. Its Division on Health serves as a clearing-house for organizations in Toronto whose primary interest is health, making joint planning and action possible.

Miss Percy graduated in 1924 from the School of Nursing of the Toronto General Hospital. The following year she enrolled in the public health course at the University of Toronto. After two years in Montreal, Miss Percy became junior assistant superintendent with the National Office of the Victorian Order of Nurses for Canada, in charge of the publicity program. After seven years with the Order, Miss Percy joined the staff of the School of Nursing, University of Toronto, which position she left to join the R.C.A.M.C.

As past chairman of District 8 and later as second vice-president of the R.N.A.O., Miss Percy has demonstrated her interest in association work. Her many friends in the nursing profession welcome her back and wish her well in her new field of leadership.

May E. Reid has been appointed supervisor, D.V.A. Wing, Regina General Hospital, after serving with the R.C.A.M.C. since 1942. Prior to entering the School of Nursing of the Regina Grey Nuns' Hospital, Miss Reid taught school for some years. Following the completion of the course in teaching and supervision in schools of nursing taken at the McGill School for Graduate Nurses, she became instructor at St. Paul's Hospital, Saskatoon, which position she relinquished to join the army nursing service. During her years in Saskatoon, Miss Reid held office as president of the Saskatoon Registered Nurses Association and also as chairman of the Hospital and School of Nursing Section of the Saskatchewan Registered Nurses Association.

Marion Christine Livingston, who has been second assistant superintendent of the Victorian Order of Nurses for Canada



DOROTHY M. PERCY

MAY E. REID

since 1943, has been appointed to succeed Miss Margaret Moag as superintendent of the Montreal Branch of the Order.

After receiving her professional training in the School of Nursing of the Hamilton General Hospital in 1930, Miss Livingston was awarded a graduation scholarship on which she proceeded to the University of Toronto School of Nursing, specializing in public health nursing. Miss Livingston returned to the Hamilton General Hospital, for two years, as social service nurse in the out-door department. For the next four years, she served as a staff nurse with the Ontario Department of Health. Joining the Victorian Order of Nurses in 1938, Miss Livingston progressed rapidly from staff nurse in Montreal, through nurse-in-charge of the Moncton Branch to be a supervisor with the National Office of the V.O.N. Her broad understanding of current problems fits her admirably for the important position to which she now proceeds. Of Irish descent, Miss Livingston brings a wealth of personality to her new duties.

The Victorian Order of Nurses for Canada announces with pleasure the appointment of Eleanor Scott Graham to the National Office staff as second assistant superintendent. A graduate of the Vancouver General Hospital, with B.A.Sc. (nursing) from the University of British Columbia, Miss Graham obtained her M.S. degree from the University of Chicago in 1945, followed by a brief period of observation of public health developments on a Kellogg Foundation Fellowship.

Miss Graham was on the staff of the Metropolitan Health Committee, Vancouver, for three years, after which she joined the Provincial Board of Health and worked in the rural field as supervisor in Duncan, B.C. During the war, when Prince Rupert became the focus of much activity, Miss Graham was chosen to assist in the development of the health unit program, later opening a district at Powell River, B.C. We wish Miss Graham success and happiness in her new work.

Notman, Montreal

CHRISTINE LIVINGSTON

Brigadier Margaret McAulay, for thirty-eight years actively associated with the welfare work of the Salvation Army, has retired from the superintendency of Grace Hospital, Vancouver.

Brigadier McAulay's first appointment, in 1908, was in Ottawa. The social ser-

Sherick, Toront

ELEANOR S. GRAHAM

BRIGADIER M. McAULAY

vice work among the young unmarried mothers was and still is her greatest interest. She carried on the same type of work in Saint John, N.B., then transferred for a short period to Calgary's children's home. Early in 1914 she took charge of the girls' home in Vancouver. Three years later she went to Winnipeg where she took her nurse's training at Grace Hospital. From 1923 to 1940 she served in the institutions sponsored by the Salvation Army in Vancouver, Regina, Calgary, and Halifax, returning finally to the position which she has recently vacated. In every community. Brig. McAulay has worked with the Courts in assisting young women who were drifters.

So full was her life with interest in and service to others that Brig. McAulay has never had time to feel bored. Now she will have time to develop the hobbies which her busy and active life has denied her. We all wish her long years of happiness.

Obituaries

Following a brief illness, Alice J. Scott passed away on November 6, 1945. Only those who knew her intimately could know how full of good deeds was her life, for she was not wont to discuss her acts of kindness and mercy.

ALICE J. SCOTT

Miss Scott was born at 40 Yonge Street, when Toronto was still known as Yorkville. She received her early education at Miss Brown's Academy for Young Ladies, situated on the present Asquith Avenue. After completing her academic schooling she entered the Toronto General Hospital and graduated from that training school for nurses in 1892. Following her graduation she accepted the position of head nurse of the women's pavilion. In that capacity she gave such good service that Dr. Temple, an outstanding surgeon of that day engaged her to take charge of his own private hospital on Bellevue Avenue. She became president of the Toronto General Hospital Alumnae Association in 1899 and served for two years. She continued all through the succeeding years to take a keen interest in the affairs of the alumnae.

The many positions that Miss Scott filled during her professional career are an indication of her ability as an organizer. She was appointed one of the five head nurses on the staff of the Royal Victoria Hospital, Montreal, when that hospital first admitted patients in 1894. She also served in an executive position at the Kingston General Hospital, and was chosen to help plan and to take full charge of the Ross Memorial Hospital, Lindsay. Returning again to Toronto she held for some time the position of superintendent of nurses in Grace Hospital. Her last professional position was that of supervising nurse for the students of St. Margaret's College where she remained for a number of years. After her retirement she continued to take part in the activities of the college.

In 1908 Miss Scott accompanied Mary Agnes Snively to the congress of the International Council of Nurses held in London, England. An interesting feature of this trip was the placing by Miss Snively of a wreath of flowers from the Canadian nurses on the tomb of Queen Victoria. Incidentally, Miss Snively and Miss Scott were the first uncrowned heads to be granted admission to the tomb.

In 1917 Miss Scott retired from professional life to care for her mother who passed away in 1919. From that time until her last illness she took an untiring interest in all worthy causes. The Needlework Guild of Canada claimed her especial attention. She was convener of one of the Circles, and found a keen delight in the competition of her Circle for first place in the collection of garments each year.

Besides these more public duties she was never too busy to interest herself in and help anyone less fortunately situated than herself. Indeed, when she seemed rather frail she found opportunities for service, if it was only to share a wayfarer's burden of parcels across a busy street.

Truly it may be said of her that she lived the motto of her alumnae association—*Ut Prosim.*

Kathleen Hill died recently after an illness of several months. After attending the University of New Brunswick and MacDonald College, Ste. Anne de Bellevue, Miss Hill entered the Royal Victoria Hospital at Montreal from which she graduated. Later she took a postgraduate course at the McGill School for Graduate Nurses. Possessed of executive ability of a high order, her adult life was given to hospital service in which she held responsible positions from British Columbia to Nova Scotia. She was on the staff of a children's convalescent home in Hartford, Conn.; the staff of the Victoria Public Hospital, Fredericton; superintendent of the Trail-Tadanac Hospital in B.C.; superintendent of the Colchester Co. Hospital, Truro, N.S.; and superintendent of a hospital at Iroquois Falls, Ont., her last position. Miss Hill's health had not been good for some time and she returned to St. Stephen to reside about a year ago.

Margaret Adams, a native of Almonte, Ont., succumbed to a long illness at Brockville, Ont., recently. Miss Adams received her nurse's training in the United States where she was employed until her return to Canada fifteen years ago. Latterly, she has worked in Almonte, Carleton Place, and Pakenham, retiring to Brockville five years ago.

Florence Charters, who was a graduate of the Hospital for Sick Children, Toronto, died recently after a prolonged illness. Miss Charters served overseas in World War I, being attached to No. 4 Base Hospital, and serving in England, France, and Salonika. She was associated with the D.S.C.R. for many years before her retirement.

Frances Ellen Cooper, a 1934 graduate of the Vancouver General Hospital, died recently after a short illness. She had lately returned from service overseas and was on duty at the Vancouver Military Hospital. She was given a full military funeral in Moose Jaw, Sask.

Mamie Johnston passed away after a lingering illness at Deer Lodge Military Hospital.

Jessie Vera Moberley, who has been associated with the Infants' Home in Toronto for the past twenty-six years, died recently after a short illness. A native of Fort William, Ont., Miss Moberley received her early education in England. She received her nurse's training in Minneapolis and went to Victoria, B.C., where she was superintendent of the Isolation Hospital. In 1919, she became matron of the Infants' Home and at the inception of the foster home plan was made executive secretary.

Audrey Marion (Clemens) Smith, a graduate of St. Joseph's Hospital, Victoria, B.C., died a short time ago. Before her marriage, Mrs. Smith was on the staff of the Lourdes Hospital, Campbell River, B.C., and later took a postgraduate course at the Provincial Mental Hospital, Essondale, B.C.

Anne Marguerite Stephen, a graduate of the Winnipeg General Hospital in 1928, died recently. Miss Stephen had engaged in private duty nursing in Winnipeg throughout most of her professional life.

Florence Stevenson, one of the oldest members of the Alumnae Association of Ontario Hospital, London, Ont., died on November 21, 1945. She was a member of the first graduating class in 1904.

Malnutrition Survey

A new system of spotting and treating cases of malnutrition has been put into effect in Italy on a nation-wide scale as the result of work by two young nutrition scientists on the staff of the United Nations Relief and Rehabilitation Administration.

The plan is to identify malnutrition as a notifiable disease, the same as infectious or contagious maladies, in a nation-wide survey by health authorities and to record all cases for treatment, according to word received in Washington from Dr. A. P. Meiklejohn, special nutritional consultant in UNRRA's London headquarters.

The nation-wide survey in Italy has covered both children and mothers thus far. It was made possible by the UNRRA feeding program. Every doctor in charge of clinics, orphanages, or maternity welfare units is required to furnish a standard report on clinical evidences of malnutrition when arranging for UNRRA relief. School feeding programs and additional rations for expectant mothers have been established by UNRRA for some time. These are aimed at supplementing ordinary rations by at least 750 calories a day.

Dr. Meiklejohn said that the basis for additional feeding has been proof of economic need, and clinical evidence of malnutrition is accepted as clearest proof of such need.

In addition to furnishing a basis for combating effects of underfeeding, the system of reporting all cases will make possible more complete studies of resulting ailments on a community as well as an individual basis and provide a better scientific approach to the problem.

"The results of this important innovation," Dr. Meiklejohn said, "will be watched with interest in other countries. A similar nutritional survey in terms of medical need would be desirable in every country. So far as I know, there is no other in which anything like it has been attempted. It constitutes a new approach to the problem of improving nutrition on a nation-wide scale.

All the reports from the examining physicians are sent to the Ministry of Health and will furnish materials on which a food program for the entire country can be planned. Thus, the distribution of food will be directed in the most economic manner toward promoting a high standard of health".

—*UNRRA Bulletin, No.* 331

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association

The Relationship of Public Health Nurses and Social Workers in the Field

LILLIAN THOMSON

In the sub-zero of a Saskatchewan evening, Miss Moffatt, public health nurse, leaned forward to turn her car key and at the same time she frowned back at the house just visited. "I told that social worker what Mrs. Olichuk needed a month ago and she hasn't done a thing yet!" she declared.

And on the same evening, Miss Hall, social service worker in Montreal, gingerly descended some icy steps. Crossly she looked up at the apartment house and muttered, "Well the nurse certainly got Mrs. Cartier all tangled up that time!"

Misses Moffatt and Hall are two of the many workers who daily, for good or ill, build the relationship of public health nurses and social workers. That relationship matters more to the people they serve than to anyone else. So to share or disperse Miss Moffatt's ill-humour we should look for its source in the Olichuk kitchen. A month ago as she warmed her hands by the stove, Miss Moffatt pondered whether this was a problem for the social agency. She did well to ponder because half of the difficulties between our harassed workers arise over referrals. At this point certain questions must be faced.

What does Mrs. Olichuk think about it? Time was when it would have been sufficient to ask, "What is best for Mrs. Olichuk?" Today, we concede Mrs. Olichuk's right to decide for herself. Therefore Miss Moffatt's responsibility lies in getting the viewpoint of the family as to their needs and in describing how the social agency might help to meet those needs. There are certain exceptions however. Sometimes the patient is in great emotional turmoil (for example, some cases of unmarried parenthood) and for the moment is quite incapable of decision. Another exception might arise in case of child neglect.

With Mrs. Olichuk's consent up one sleeve and the social service exchange clearing up the other, Miss Moffatt may approach the agency under an indubitable green light. She should state the health picture clearly and simply. She will not, of course, withhold vital information. Recently an institution referred a young woman to a case work agency but withheld the fact of pregnancy. The plans made by the social worker were all wrong, and you would accuse me of morbid exaggeration if I told you the consequences. You may say: "But why didn't the caseworker investigate for herself?" The answer is that we try to spare the client a series of investigations. Usually the withholding agency claims that its information is confidential. This claim clearly implies doubt of the other agency's ability to maintain professional confidence. So serious a doubt should be examined in conference between the two groups and not allowed to continue underground.

In addition to health data, Miss Moffatt will describe family attitudes factually, for instance, that fifteen-year-old Mary says she hates being tied to the home. Then she will state the problems with which she thinks the social agency might help. It is not wise to assume that the agency is bound to help or to say how aid should be given. While a modern social service agency is better equipped to give constructive help than those of a previous generation, it is also quicker to recognize situations in which its efforts would likely be destructive or abortive.

Maybe I should warn you that family agencies often grumble about nurses who never refer anything except need for financial assistance. Nobody likes to be mistaken for her grandmother. The old Charity Organization Society which died years ago was preoccupied with relief. Its daughter was the family agency of the 1920's, which, although it gave relief because public assistance was weak, was influenced by the new psychology and found its primary interest in behaviour. Today's family society is a grand-daughter living in the dawn of social security and is chiefly concerned with relationships in the home. To understand the social worker's gloomy attitude if you refer only relief work you might recall your own irritation with people who refer to you only bedside nursing care, as if to puff away all your educational and other skills.

But Miss Moffatt doesn't do it to annoy. She may simply fail to recognize any social problems except an obvious need for food. She is like the social worker who never suspects a physical condition unless perchance there is a far-advanced pregnancy. She may never have acquired the habit of noting danger signals in behaviour. No little mental fog-horn warns her of breakers ahead when told that Anna is a nice quiet girl who avoids other young people. The abundant literature on the subject of recognizing incipient problems should be familiar to nurses, teachers and social workers alike.

But there are pitfalls even for the informed observer. Miss Moffatt might call a group-work agency and ask that Anna be put in a group because she won't associate with young people. But Anna may not be ready for a group, whether in a club, camp or residence. A better plan would be to tell the group-worker about Anna's predicament and discuss what would be helpful. Such discussion might lead to Anna being referred to a guidance clinic for counsel before trying her in any group. The general principle is that major responsibility in analysis and planning should rest with the social agency whenever the problem in question involves personal relationships, behaviour or social welfare.

Let us suppose that a social agency has accepted responsibility. There may be no professional reason for further connections between the nurse and the family. Here comes Miss Moffatt's hardest test. Like patients, we too have human feelings and it warms our hearts to feel that someone has more confidence in us than in anyone else. It may be difficult for the nurse to convince herself, and therefore Mrs. Olichuk, that the social worker could be more helpful than she, and if she is a lonely person who needs Mrs. Olichuk's appreciation she will face a hard exercise in self-control.

If her services are still required it may be genuinely difficult for the nurse to restrict herself to her own field and offer no comment on the social problems, particularly if the family asks her advice as the person with whom they are better acquainted. It is surprisingly easy to stumble into a situation where contrary advice is given or at worst where the family plays off one worker against the other. Moreover the fact that the nurse is busy and useful in practical ways makes it look as if the social worker is doing very little as she sits interviewing. And the social worker may have neglected to explain her plans. Or she may seem unimpressed by the fact that the success of medical care waits upon social adjustment. Or she may not attach importance to the nurse's feeling of accountability to the physician. Indeed, since there is no comparable responsibility in the activities of most social workers, the latter are prone to forget its existence in the nursing field. These are snags to be unravelled with understanding and imagination and the nurse should not hesitate to point them out as actualities in her work.

Of course the nurse may simply disagree with the way the social worker is carrying on treatment. When Miss Moffatt says the social worker hasn't done a thing yet, she is questioning the social treatment just as someone might criticize her own nursing methods. Maybe she has not stopped to remember that social treatment should not be equated with financial assistance. Oftentimes the best treatment involves withholding relief. But disagreements may not be connected with relief. Let us hasten back to Montreal and see why the social worker, Miss Hall, is muttering complaints about the nurse.

Is Miss Hall just a shrew? Nurses have been known to say that there is a peculiar aggressiveness about social workers. That may well be. Our profession is new everywhere and practically unknown in many places. There is a consequent tendency for the public either to overlook the worker's capabilities or else to expect the performance of miracles. It is not an easy environment. But maybe there's a simpler explanation. We've all worked with the person who was born to keep us humble. When she is a member of our own group we merely sigh: "That's Agnes for you!" But if she is a member of another profession we snap. "That's a teacher for you!"

But we will give Miss Hall the benefit of the doubt. She has just interviewed weeping young Mrs. Cartier. Mrs. Cartier's husband abuses her. The nurse, independent in her own life, has indignantly advised Mrs. Cartier not to let that man come near her again. What she is saying, in effect, is: "This is what you should do because it is what I would do in your circumstances for I must live with dignity and be respected." On her part Mrs. Cartier feels and says that she wants to be dignified and respected because everybody wants to be, of course. That other feeling of hers — that she hankers for Mr. Cartier's excited attention — is unexpressed even to herself for whoever heard of such a thing? Well, of course, Miss Hall had heard of it. She was even planning a careful discussion on that very subject in the hope that Mrs. Cartier might achieve a working knowledge of her own mixed feelings. But what's the use now? Mrs. Cartier naturally looks up to the nurse as a person of authority and comforting skills. So she sits weeping in her grievous struggle to base her conduct upon emotions that are appropriate not to her, but to a quite different person. If it's any comfort to anybody, the nurse is now revenged for the times when Miss Hall gave patients the most surprising dietary advice because she herself found a vegetarian regime so energizing. It's the same thing.

To put it a trifle more formally, social workers today strive to be scientific in attitudes and methods. Oftentimes, student nurses have regarded me doubtfully upon hearing this statement. They thought I strained the quality of mercy. Their doubts did them credit, for the viewpoint that human personality can be examined, diagnosed and treated scientifically does suggest something distastefully impersonal. It is also misleading, since we cannot explore personality with laboratory equipment. Yet in our century the new social sciences teach us that behaviour has meaning, that it may be observed and understood by the practitioner and it may be understood and modified by the patient with the help of the practitioner. Most of the social workers with whom nurses work in the field, whether their method is that of casework or group work, are practitioners in the area of human relationships.

That area is recently discovered and incompletely surveyed and before our eyes the great structure of social security is now being built over it. The responsibilities of both our professions will be modified by the social security program. We may have to do less to keep the patient's body and soul together and more to enrich his total experience. There will be greater stress on our teaching roles and new ties with education groups. We will have inescapable responsibilities to the new federal Department of National Health and Welfare for a network of uniformly good health and welfare standards cannot be flung across Canada solely by a superman department. Nurses and social workers in the field will discover and report gaps and repair breakdowns. The final test of the new securities will come in the kitchens of the Olichuks, observed by Miss Moffatt as she toasts her hands by the stove, and in Miss Hall's Montreal office where Mr. and Mrs. Cartier sort our their feelings about themselves and about the new world in which, miraculously, they now find themselves.

The Common Cold

The common cold affects more women than men, and hits office employees much harder than factory workers. The common cold is responsible for more than one-third of the total number of days lost in industry. There is a definite pattern to the incidence of colds, with the highest peak in December and the lowest in July. There is a definite correlation between temperature and the onset of colds, every sudden drop in temperature being followed in a day or two by a rise in the number of colds. The highest incidence of colds is found in the age group from 20 to 29 years and the lowest in the age group above 50 years. However, the percentage of time-losing colds increases with age. There were fewer colds in air-conditioned plants, with the incidence of colds highest in drafty places. More colds start on Monday than on any other day of the week, this being especially true of colds among men. Posture is an important factor, with the incidence and severity of colds lowest among those whose work necessitates walking about most of the time. Smoking apparently has little effect on colds.

—Health News Service

Correction

An unfortunate typographical error occurred in the November, 1945, issue of the *Journal*. On page 863, line 22 should read, "It is *most* often seen in children," rather than "*not* often." Dr. Humphreys informs us that tick paralysis nearly always occurs in the younger age group, mature persons seeming to be resistant. We regret this undetected error.

HOSPITALS & SCHOOLS of NURSING

Contributed by Hospital and School of Nursing Section of the C. N. A.

The General Staff Nurse in Schools of Nursing

Isabel MacDougall

According to a statement in the manual of Essentials of a Good School of Nursing, "A good teaching clinical field requires a permanent general staff in sufficient numbers to insure a stabilized service, and to safeguard a balanced program for nursing students". This quotation implies a great deal. It means that the general staff nurse is needed in our hospitals across Canada. She is wanted because of her own nursing ability and the nursing care, par excellence, that she can give to the patient. She is needed for the contribution she can give to the educational growth of the student nurse, through personal daily contact, and through the stabilization of nursing service and release of the student for the furthering of her educational program. She is now officially called "the General Staff Nurse" meaning a person who is part of the hospital rather than her old title "the General Duty Nurse" meaning a person who merely fills in, as it were.

Since 1930 when she first began to come into our hospitals the prestige of the general staff nurse has been increasingly developed and expanded, although at a rather slow rate. The late war has been responsible for many changes and developments in the nursing profession, and the future role of the general staff nurse may be much more important than in the past. In 1932, according to Dr. Weir's Survey of Nursing Education in Canada, 18 per cent of Canadian nurses were engaged in institutional nursing. In 1943, according to the Survey of Nursing made by the Canadian Nurses Association under the auspices of the Canadian Medical Procurement and Assignment Board, this number had changed to 48 per cent. This increased demand for institutional nurses was due in part, the report stated, to an increase in bed capacity and bed occupancy, but also to a growing demand on the part of the public for an increase in the quantity and quality of nursing service.

When a patient enters the hospital he is entitled to adequate nursing and medical care, this being the aim and purpose of all institutions that look after the sick. Has he not then the right to be nursed by some one who is fully trained, qualified, and experienced in nursing, just as he expects to receive medical care from a doctor who is a qualified graduate medical person? Even in teaching hospitals the medical students do not prescribe in any way for the patient. Strictly speaking then, should not the patient be nursed by a graduate rather than a student nurse?

Again quoting from the last report, "Another factor which has caused an increase in demands for graduate nurse service in hospitals is a growing realization on the part of all concerned that schools of nursing have a dual responsibility, and that educational facilities and opportunities must be provided as for students in other fields. To provide for this, general duty nurses are essential. The responsibility for carrying the major part of the nursing service in hospitals can no longer be delegated to student nurses, either in justice to them, or with due regard for the safety and well-being of the patient". In spite of an increase in the number of nurses doing institutional work during the war, the above survey reports a definite shortage of general staff nurses. What plans can we draw up now that will make this position attractive and secure enough to persuade nurses to enter it?

Recognition of the general duty nurse is long overdue. Now that she has come to the fore as an important member of the nursing profession, would it not be a good idea to capitalize on this, and sponsor her cause to the greatest possible extent, not only to her own advantage, but also to that of the hospital and to the nursing profession as a whole? The existing disadvantages of general staff nursing must be entirely done away with, if we are to accomplish our objective and bring her into our hospitals as the stabilizing member of the nursing service. The attitude toward the general staff nurse must be improved, and better personnel practices adopted by the administrators of hospitals. The three main disadvantages to this type of work have been too long hours, not enough pay, and the lack of recognition accorded this position by others in the nursing profession, accompanied by the lack of any chance for promotion.

The Canadian Nurses Association has already done much towards furthering the recognition of this group, and their interests are now sponsored by the General Nursing Section. Provincial chairmen were appointed who formed committees to study the problem, and in the November, 1944, issue of *The Canadian Nurse*, Miss Pearl Brownell, chairman of the General Nursing Section, has published their report. They reported a steady increase in the number of hospitals on an eight-hour day, and also considerable improvement in salaries paid by the average hospital. Living conditions vary from good to very poor for these girls, particularly in rural areas, and holiday time granted to them varied from holidays taken at their own expense to four weeks with pay. In summing up her report, Miss Brownell states, "While during the last two years some improvements are noted, it is still in a most unsatisfactory position. Much remains to be done before we reach the day when general staff nursing will come into its own as one of the most desirable fields of nursing".

We know how essential her services are to the hospital that employs an all-graduate staff, but it is now recognized that too little emphasis has been placed on the importance of the position she fills in the hospital connected with a school of nursing. Up to the present the general staff nurse has been described as a nurse who is engaged in the actual bedside care of patients in hospitals, but could she not also be defined as one who is engaged in helping to further the educational growth of student nurses? The highest standards of student education cannot be maintained, and the best possible care given to patients if hospitals are entirely dependent on the student body for nursing service. I am sure we would all agree that nursing education is aspiring to a professional level. In this article I would like to make a plea that the position of the general staff nurse be elevated to a place of greater importance in the nursing profession to help us accomplish this objective.

I think that general staff nurses should be on our wards in sufficient numbers to enable the clinical and classroom instruction to be carried out according to the curriculum of the school. This would at the same time ensure the adequate nursing care of the patients. Up to the present we know that in many wards the student nurses are carrying almost the total nursing load. This is not sound either from the point of view of the school or even the hospital itself. I have already spoken of the right of the patient to be cared for by a graduate nurse. But what does this mean in terms of the training and education of the student nurse? It means, for example, that a second-year student is making empty beds long after that procedure has ceased to be of educational value to her. It means that a third-year student is doing many jobs that are simply routine rather than new learning experiences which as a student she should be continually receiving. Can we envision what a permanent general staff would mean on a ward of this kind? It would enable us to train and educate students according to an uninterrupted program, the dream of any director of nursing education. It would mean that theory and practice could be ideally correlated, because students could be rotated through the various essential services according to schedule. What a wonderful thought to think that the nursing service would not be disrupted visibly when students are rotated or away at class. There would be someone there to care for the needs of the patient. How satisfying this would be from the point of view of everybody concerned — the patient, the nurses and even the hospital. Would it not mean something to the reputation of the hospital? I think it would.

Above all it would mean we could have an eight-hour day for student nurses. For years now the long hours of students have been retarding their educational development. After a long, tiring day on the wards nurses are mentally as well as physically exhausted, and simply cannot study. Our nursing educators agree that an eight-hour day for student nurses is ideal, and when this is accomplished nursing education will have taken a great step forward. A general nursing staff could bring this into force.

The question might be asked—how many staff nurses would this program require? No definite studies have been made that would tell us exactly the number of graduates a ward would need, but if we began with one or two, depending on the size of the service, a great deal could be learned by experience. Nursing education would be carried on more as it is in our university schools of nursing, and their ideas would be a source of help in the formation of plans.

The opportunities and satisfactions of this field of nursing are often not fully recognized and understood, and this lack of information may prevent nurses from doing this type of work. It does have much to offer professionally, financially, and socially. The professional opportunities are numerous. First, it offers the new graduate a wide choice as to what type of nursing she prefers, that is, if the administrator, as she should, has regard for individual preferences when considering her assignment. The general staff nurse should consider this an opportunity for specialization in her field of interest, be it medicine, surgery, pediatrics, obstetrics or any other branch of nursing. She has a splendid opportunity for professional growth by daily applying the principles and techniques she learned as a student. In this way, too, she is preparing herself for greater responsibilities in the future. Many of our future head nurses and their assistants will be chosen from the ranks of the general staff nurses. Qualities of leadership will come to the fore during this time. Also, there are exceptional advantages for further study in institutions where the general staff nurse is included in staff education programs. She should be present at ward rounds and staff conferences, and be recognized as someone who has something to contribute to the discussions. Secondly, the fact that she must be an example to student nurses should inspire her to develop into an even better nurse. Nurses-in-training can be most critical, and they should see in the general staff nurse, in both her personal and professional conduct, the attributes they themselves hope to attain by the time they have concluded their training. Finally, regardless of what branch of her profession she chooses to follow, modern nursing education lays heavy emphasis on the importance of the nurse as a teacher. The general staff nurse has a wide opportunity in this phase of her work, because she is in such close contact with not only the patient but also their families and friends. She sees the patient as a person, a member of a family, and of a community, and utilizes to the full every teaching opportunity in this respect. In an article entitled "The General Staff Nurse Teaches Health", Miss Marion Sheehan has two conclusions to make as regards general staff nursing:

> 1. It is our duty to arouse in our patients a strong personal interest in health and a hygienic way of life for themselves and their neighbours.
>
> 2. In fostering this interest we must aim to have it enthusiastic and actively sincere; so that when patients leave our care their interest will grow into an actual effort to make use of the vast and ever expanding resources for better public health.

Financially, her condition can be quite secure whether she chooses to live in or out of residence. I think the administrators of the future will realize her need of security in this respect, and salaries will be paid on a scale commensurate with ability and service given.

The social opportunities afforded are well worth mentioning. She is able, because of her regular hours and time off duty, to plan recreational and social activities that will keep her satisfied. As we know, this factor is one of the great drawbacks of our profession, but I think that during a period of general staff nursing, opportunities for cultural improvement could be utilized to the fullest degree.

Most of us do not realize how the mental health of the nurse can contribute toward the recovery of the patient. This aspect has been stressed by Dr. S. R. Laycock in an article published in the January, 1945, issue of *The Canadian Nurse*: "Certain it is that only as the nurse-student or graduate—finds rich satisfaction for her own needs will she be able to do that most difficult of tasks — so to minister to the emotional health of the patient that sick *persons* rather than merely sick bodies will become well". He goes on to say that these basic personality needs are five in number, namely, emotional security, independence, achievement, recognition, and a sense of personal worth. There is no reason why general staff nursing should not present a reasonable fulfilment of these needs — if adequate personnel practices are carried out.

Much has been written both in the United States and Canada about improvements in the employment conditions of the general staff nurse. Recommendations have been worked out in the United States and are incorporated in the booklet entitled "The General Staff Nurse", a study of the status and problems of the hospital staff nurse, published in 1941. They have been accepted and published by the Committee on Nursing of the Canadian Hospital Council. I can do no better than to quote these suggestions, and to add a very strong plea for their adoption by directors of nursing services across Canada:

STATUS

(1) That hospitals employ only graduate registered nurses for general staff nursing. This should not prevent the employment, by their own school, of nurses who have finished their training and not yet become registered; (2) that the status of the general staff nurse in the hospital be clearly defined, with special reference not only to her

relationships to other members of the nursing personnel, but to other members of the hospital personnel.

Her status as a graduate nurse should be definitely recognized. Her status as a member of a recognized professional group should be fully accepted and she should be accorded the prestige commensurate with the responsibility assigned to her as a member of the nursing group.

SELECTION AND QUALIFICATION

That, in the selection of graduate nurses, attention be given to character, personality traits, and type of preparation, not only in the nursing arts and sciences, but in the clinical fields to which she is assigned.

EMPLOYMENT CONDITIONS

That concerted effort be directed toward the adoption of more acceptable standards of employment for general staff nurses, to the end that the well prepared nurse may become interested in this important type of nursing service:

1. *Hours of Work*: (a) They should represent a reasonable schedule. A 48-hour week is a desirable schedule toward which to work, and hospitals should endeavour to achieve it as soon as conditions will permit. In some instances a six-day week and an eight-hour span will be found desirable. In other situations the span may be longer, but should not exceed twelve hours. (b) Whenever possible the schedule for time off duty should be posted far enough in advance to permit nurses to make reasonable plans for off duty time.

2. *Assignment*: Assignment should be made on the basis of the personal and professional qualifications of a nurse. The nursing load should be such as will permit her to give good nursing care to patients, and which will result in personal satisfaction to herself. Choice and permanency of service should be given every possible consideration.

3. *Vacations*: The vacation schedule should be in harmony with the vacation schedule that prevails in the balance of the personnel.

4. *Salaries*: (a) Salaries for general staff nurses should be commensurate with those of other nurses in the community, the duties and responsibilities called for by the position, and the length of time for which the nurse is employed as well as the quality of service rendered. (b) A range for salaries should be established with due regard to the salaries paid to other nurses in the community and those of the workers in the hospital. (c) When general staff nurses are employed on a daily basis they should be paid at a relatively higher rate than when employed on a monthly basis. If perquisites are given as part of the salary, a definite monetary value should be placed on each perquisite.

5. *Health Services*: (a) A health service should be established and should include a physical examination on employment and at regular periods thereafter. (b) Wherever possible arrangements for hospitalization should be made according to one of the acceptable hospital plans. Where acceptable plans cannot be used for the hospitalization of nurses, a liberal attitude towards the hospitalization of staff nurses should be formulated and carried out by the hospital staff.

6. *Staff Education*: A well planned program of staff education should be established and followed which will provide opportunities for both an intramural and extramural program.

To these recommendations I would like to add that all hospital boards controlling training schools should be encouraged to consider the advantages of including a permanent general staff in their nursing service. I am certain they could be convinced of its efficiency in promoting the reputation of the hospital. It is a recognized social fact that the hospital should employ a general graduate staff to ensure a consistently good quality of nursing to patients. At the same time it would be a boon to the nursing profession in that it would permit the educational program of the student nurses to be carried out on a long sought professional level. Let us do all in our power to further the role of the general staff nurse.

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A New Skin Disease

Studies of the occurrence of a new skin disease, which has been named atypical lichen planus and is known to the soldier as one of the varieties of "jungle rot", were recently announced.

Following the first Pacific island invasion, it became necessary to evacuate a growing percentage of men from battle areas because of skin diseases which are common in the tropics. Soon after the beginning of the Buna campaign in early 1943, a number of patients with a similar skin disease which was unfamiliar was noted. Further observation made it evident that a new disease was being encountered.

The first reports containing descriptions of this new disease, which came to be called atypical lichen planus, were submitted by two army dermatologists in the Southwest Pacific. They believed that atabrine, the drug which proved of such exceptional aid in reducing malarial attacks, was probably the underlying cause of the disease.

Army doctors emphasize that the possible relationship of atabrine to atypical lichen planus does not reflect upon the usefulness of atabrine for the treatment of malaria. The skin disease has appeared only in about two or three per thousand of those in the Southwest Pacific who took atabrine regularly for some months. Atypical lichen planus apparently arises partly because of an unusual sensitivity to atabrine. Doctors are well acquainted with the fact that occasional individuals are sensitive to certain drugs such as quinine, the sulfa drugs, and even aspirin.

Although medical officers believe that atabrine is an underlying cause of the disease, they recognize that many other factors besides atabrine are probably contributory. These include skin injuries and irritations of many kinds, excessive exposure to sunlight, profuse perspiration, dietary deficiencies, and emotional and nervous factors. Older men have been found to be more susceptible than younger men, and the disease occurs among the nurses and WACs as well as among the men.

Medical officers soon learned to recognize atypical lichen planus in its early stages and are able to prevent it from spreading to other parts of the body. In all but a small percentage of cases the disease has cleared up under treatment. To relieve the public and the families of patients of unnecessary worry, army doctors emphasize that atypical lichen planus is not contagious.

Atypical lichen planus gets its name from its resemblance to the well known skin disease, lichen planus. The type of skin lesions in the disease differs with the patient. The disease usually first occurs in itchy, oozing, reddish or purplish patches on the skin. These patches may remain the same for several weeks or they may spread rapidly. Some patients develop a later stage in which raised scaly patches appear, often on the arms and legs.

Following the acute stage of the disease, the inflamed patches leave purplish or brownish areas and often cause a temporary closure of sweat glands with a consequent lowered heat tolerance. In some cases patches of hair are temporarily lost.

—*News Notes No. 29*

GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

Back to Nursing

M. MacLeod

Back to nursing was an exhilarating experience for me, perhaps more keenly felt because I had served as a supervisor on one of the floors in this same hospital thirty-three years ago. Then Saskatoon, as a city, was seven years old, without street-cars or paved streets; deluged with real estate men; visited by epidemics; bolstered by babies; buffetted by prairie gales and expanding rapidly over the surrounding plains.

Utilities, including street-cars and paved streets, increased at a surprising speed as this new city of western Canada became more thickly populated, until now, in its fortieth year of cityhood, it has a population of 45,000 — lessened somewhat during the war — covering a large area of prairie land and served by two general hospitals, modernly equipped, capacities greatly increased and staffed proportionately.

This is not intended as an historical sketch of this city nor of its City Hospital where, after registering in the National Emergency call for graduate nurses in 1943, I had responded to the call for emergent duty. It is only a resume of my experiences while there, things brought to mind and my associations with the younger nurses.

I went for ten months daily, except Sunday, which was a day off for the extras. My hours were two to six in the afternoon.

Being away from institutional nursing for a long time, it was interesting to note the advancement made in the nursing profession particularly in the theoretical phase and in the equipment supplied for the convenience of the nursing staff. Classes are more numerous, subjects more extensively taught, lectures more frequent and study-books more detailed than when I trained in the early part of the century, from 1903-06. Yet, there seemed no decisive change in procedure, except that methods are clearly set out in an indexed volume which can be conveniently studied and readily referred to.

Treatments are much the same as those with which we older nurses are acquainted. Intravenous, interstitials, and blood transfusions are more commonly used now. The Murphy Drip, new in my training days, is resorted to occasionally. Fowler's position is as popular as ever, though more favourably adjusted by the convenient construction of the bed. Then, there are the new drugs. But why talk about drugs? I marvelled at the number of new ones, seemingly hundreds with unpronounceable names, though among them many of the old reliables. I heard one student nurse express surprise at the written order for Balsam of Peru to be used for a sloughing incision. That application was new to her while old to me. Another nurse was interested in the treatment of *cupping*, having seen it for the first time in her training.

These minor examples created within me a new interest, a renewed sympathy in the work and an urge to grasp anything new.

The greatest change seemed to be in the consideration given to the welfare of the nurses, the gradual approach of the preliminaries to the training field; the classes and lectures held during hours set aside for instruction, instead of during their off duty hours, and the sympathetic attitude towards new graduates.

Preparing myself for the event, as event it was in my busy life, I looked upon it as an opportunity and a privilege. I had taken part in different organizations but, realizing that an emergency had occurred in this hospital, I deemed it my duty to offer my services. I felt like an old war-horse put back into harness. I was thrilled and enjoyed every minute. I had no strange feelings towards the work. I was made to feel at home.

Coming on duty one day, I emerged from the elevator and was met by a young graduate who greeted me with the words: "I hope I'm like you when I'm as old as you." No resentment from me! That was a compliment. One young man called me "Mom." Another older in years, perhaps bordering on the senile, told me, when I appeared at his bedside in answer to his light, that he and I had met too late in life! Someone else, comparing me to some others, told his wife that I put personality into my work. Now, who wouldn't enjoy going back to nursing under those circumstances — even if your hair is gray!

Often reference was made by different student nurses to the similarity of my cap and theirs. Thereby hung a tale which I related, telling them that their caps and pink uniforms were copies of our school uniform instituted by one of our graduates, a classmate of mine, when this school was put on an organized training basis. This was interesting news for them.

Great credit is due those who pioneered in the uplifting of the nursing profession, and to those who have continued in the great task bringing it to such heights as are noticeable today. Great progress has been made in this work which, in its exactness, still demands the very best in everyone, be she student, supervisor or director.

We have reached a great era in world history. The tumbledown world of today is very demanding, calling for the best in all of us. It will be greatly helped back to normalcy by the humanitarianism of nurses. Their training and the experience of those who have served in various parts of the war-torn world will creditably serve our own Canada in its re-establishment to peace. Nurses are adaptable. Homes, communities and organizations are greatly helped by nurses taking part in their activities.

I wouldn't have missed the time spent with the modern nurse for anything I know.

Preview

Should student nurses live in residences or should they be permitted to live at home as university students do? Are there any advantages to be derived from the close co-mingling which characterizes life in a nurses' home? By courtesy of *The Canadian Hospital,* we have been privileged to reproduce Elizabeth K. McCann's thoughtful digest of opinions upon this topic.

Nursing Education

Contributed by

COMMITTEE ON NURSING EDUCATION OF THE CANADIAN NURSES ASS'N.

Should Universities Include Schools or Faculties of Nursing and Award Degrees in Nursing?

DOROTHY DUFF

Editor's Note: A short time ago the question which appears as the title of this article was being discussed by a group of nurses representing widely varied experience. As part of this discussion the following paper was written by Miss Dorothy Duff, formerly of Saskatoon and now living in Toronto. Miss Duff presents opinions from some well-known educationists — British, American, and Canadian. As it is of the greatest importance to us to follow this thought from the general field of education, Miss Duff has agreed to the use of this paper on the Nursing Education Page of our *Journal*. Whether we agree with her ideas or not, whether we think these opinions fair or prejudiced, broad or narrow, we should be informed concerning the wide range of the argument which is influencing the development of professional education in the world of today. Probably the most important lesson which the nursing profession must learn is that we need to be fully informed concerning these general educational developments, and that we should not permit the discussion of our own educational problems apart from their relation to these general developments.

Dr. Abraham Flexner, after much experience in universities in America and abroad, wrote, in 1930, a study, "Universities: American, English, German", in which he outlined his conclusions about the modern university and its functions. In the section of his book devoted to American universities, he shows that he feels the university has lost its sense of values. He mentions degrees in nursing, as such, only once in that section of the book, and there groups together such B.S. degree courses as "nursing, drug-store practice, first aid to injured, community recreation, kinesiology, elementary costume design, and principles of coaching".[1] Thus, he seems to regard a preparation for nursing as a matter of technical education only, the study of which, he feels, could not be substituted for the subject matter of a liberal course for which a degree is given. He deplores the ". . . confusion, in our colleges, of education with training",[2] which has resulted from the creation of a variety of courses, which ". . . instead of training broadly and deeply typical minds, like the humanistic mind or the scientific mind . . . aim to enable a given individual to do a highly specific thing."[3] He states, "Vocational training may be ever so important, but the confusion of all sorts of training — vocational, domestic, scientific, cultural, in high school and college — harms all alike and the highest most of all."[4] He claims it is not sound educational procedure to jumble together courses technical in nature with those of liberal content.

Therefore, Dr. Flexner's argument is against the inclusion within the university of courses for professional training, of which a nurse's preparation would be an example, except in the well-established fields of medicine or law. He maintains that the concern of college education should be "... primarily during adolescence and early manhood and womanhood with the liberation, organization, and direction of power and intelligence, with the development of taste, with culture ... on the assumption that a trained mind, stored with knowledge, will readily enough find itself even in our complex world; that there are many things that do not require teaching at all, and that there are many things of technical nature which may require teaching, but surely not in a college or university."[5]

Sir Fred Clarke, an English educationist, who was for a short time professor of education at McGill University, addressed the biennial meeting of the Canadian Nurses Association in 1932 at Saint John, N.B. In his address, under the title, "Life, Profession and School", he discussed nursing education in thought and practice and the problems therein, from the viewpoint of the general educationist.

He deplores a technical training for the nurse which will prepare a technical expert only, without the elements of a liberal education, since "she (the nurse) is the representative of a culture as well as the bearer of healing, and she cannot well represent what she has not learned to possess."[6] He feels the nature of her profession is such that she cannot be prepared adequately without a broad understanding and appreciation of human values and relationships. He suggests that we must go a step further after we have included some liberal content in her preparation, and be assured that there is a liberal handling of the purely technical portions of the course. "It is this need for a liberal handling of the technical training itself that constitutes a strong argument for associating at least the higher training of nurses with the university, provided always that the salt of the university retains its savour".[7]

Later in his address, Professor Clarke discusses in more specific terms his outline for a nurse's training course, having a double objective "... a vocational adaptation growing out of a live and strong general culture".[8] He suggests that the preparation of instructors, administrators, and directing staff generally be on a university level, "... in a university atmosphere of breadth, leisure and disinterestedness and ... that those who take it are beyond all question of university standing."[9] He does not go so far as to say that the university should be solely responsible for such training or that degrees in nursing as such should be given. On the question of the awarding of degrees, (labels), he questions their value when they cease to be a mark of scholarship and are awarded too readily on a basis of lowered standards.

Dr. R. C. Wallace, principal, Queen's University, Kingston, Ontario, wrote an article, "Canadian University Education", which appeared in the English publication, *The Journal of Education,* October, 1942. In this, Dr. Wallace recognizes the desire in Canadian universities to make a liberal education (that is, at least a degree course in Arts) the foundation for a professional course, but that the realization of this usually seems impossible because of economic conditions. He reminds us of the very real danger in allowing people to be trained professionally with little of liberal content or methods before or during their technical training. Here, I feel, is his argument in favour of a nurse's preparation being given within a university, where the student will receive elements of a liberal education with her technical training.

Dr. Wallace goes further, with a warning that problems arise when a school undertakes to plan professional education where both technical and liberal content are essential. He goes on to say, "There is, however, the growing conviction that professional courses are overloaded with the purely technical, much of which can be learned better in actual practice; and that the eliminating of some of this material would give more balanced education to the end that the professions may be adorned, as in the days gone by, by men of fine culture. If this can be done without sacrifice to the high attainments in technique and skill of which the professions are deservedly proud, much will have been gained in our Canadian intellectual life".

The above suggestion sounds most applicable to the preparation of the nurse, where so frequently the hospital school, for economic reasons, requires an endless repetition of techniques already acquired by the student, crowding out of her day any opportunity for thought or study along liberal lines.

Professor E. R. Adair, McGill University, Montreal, in his article, "Democracy and the Universities", which appeared in the English publication, *The Journal of Education*, November, 1942, points out in what respects the American system of university education fails to be truly democratic. He expresses regret that the attitude being engendered in America is that of social stigma for the individual without a degree; so that as the degree becomes increasingly a social necessity it may lose intellectual value. The lack of recognition of what the university should offer means that what it does offer need not necessarily fit the individual for the work for which he is intellectually suited. Were he making specific reference to nursing, he would probably imply that all nurses need not and should not seek a university education, and that a process of selection based on the intellectual stature of the individual, and the type of preparation needed, should enter into any planning of nursing education on a university level.

Near the end of his article, he puts forward a thought on the democratic control of the university, which would condition the arrangements under which nurses sought to include their professional preparation within the university. Nurses, and others, often appear to assume that the university should offer them whatever bits of preparation they think necessary for a nurse and grant the degree of the university for work not comparable to the work required for other degrees. Professor Adair states that the democratic control of the university ". . . must imply that the university policy, its standards, and its methods shall be governed by the men who are its citizens, its full members, its skilled workmen, that is, the members of the academic staff".[10] This statement would exclude dictation of academic policy to the university staff from any outside group, as, for example, an association of nurses.

The demand that universities should include schools or faculties of nursing is ever increasing, due to dissatisfaction with the product of the hospital schools. In Canada, today, the movement to make the preparation of the nurse more and more the concern of the university is the predominant movement in the field of nursing education. It may be conceded that nurses have some claim on the university to aid in their preparation, but the justification for that claim is not always clear and the extent of it quite misunderstood. In support of the argument that a university should include a school of nursing, we may examine these reasons:

1. A necessity for the recognition of the nursing profession by other professions. W. G. S. Adams of Oxford has outlined the three main functions of the university as ". . . first, to lay the foundations of a liberal education; second, to train for the professions and vocations of life; third, to advance the boundaries of knowledge."[11] It is this second recognized function of the university which causes the nursing group to turn to the university in seeking preparation on a professional level. This professional standard will be demanded more and

more in certain nursing fields, to give leadership and direction in administrative and teaching capacities, by individuals both within and without the nursing profession. The qualification of a university preparation is also an advantage to the nurse in her contacts in the community with other professional groups. As Sir Fred Clarke expressed it in his, "Life, Profession and School", it offers her ". . . adequate social recognition . . . such recognition . . . to some extent a factor in efficiency".[12]

2. An essential of the nurse's preparaation is to provide a liberal as well as a vocational education.

A truly professional preparation contains technical content plus intellectual content to the end that the professional worker is able to see her work in relation to other groups, is able to give leadership in her own field and develops a philosophy of life which leads her to a better understanding of wider problems, those of the community, the nation, the world.

3. A necessity for the preparation of certain groups of workers, for example, research workers, who will carry on a highly specialized type of work.

Before asking the university to become too concerned with the preparation of the nurse, I think it is necessary that we strive for a little more clarity of thought within nursing groups on the principles of sound educational procedure. In such a study, much can be gained from a study of the development of other professional preparations. Members of the nursing profession should first ask themselves what type of preparation is necessary for a nurse. Does the profession wish to prepare more than one type of worker to cover the varied fields included in nursing practice? If nurses decide that they should prepare more than one group, one of the groups to have a broader and deeper preparation than other workers in the field, then the preparation of that one group should surely become the concern of the university. But, it is for nurses to decide what they should ask of the university, that will achieve an improvement in the nurse's preparation, while safeguarding university standards. This preparation can be so planned that it gives a broader science background, enriches the liberal outlook of the student and improves the quality of the instruction in the subject of nursing from that given in the hospital school.

In outlining a nurse's preparation on a university level, certain dangers need to be recognized. Some of these dangers are:

1. That we develop a false sense of security through organizing a course in conjunction with a university, a course which gives a liberal education, provides a better science background and gives a degree in nursing, without an improvement in the quality of the teaching of the subject of nursing.

2. That we cause the university to lower standards by giving some credit for certain work not on a university undergraduate level, thus detracting from the value of the university degree.

3. That we become too "degree-conscious", and attempt to prepare *every* nurse by a university course, disregarding her intellectual qualifications and the type of nursing practice she is best fitted to do.

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11. "Values and Opportunities", *The Journal of Education*, Nov. 1942, p. 478.
12. Clarke, *op. cit.*, p. 422.

Notes from National Office

Contributed by **GERTRUDE M. HALL**

General Secretary, The Canadian Nurses Association

Royal College of Nursing

Our British colleagues are studying many matters which bear a close resemblance to the problems with which Canadian nurses' groups are confronted. The following excerpts from the minutes of the Council of the Royal College of Nursing will be of considerable interest:

"*Nurses and the National Insurance (Industrial Injuries) Bill*: The position of the nurse who has the misfortune to contract some infection or disease during the course of her work was one of the subjects discussed by the Council of the Royal College of Nursing at their meeting on October 18.

Much work has been done by the College on this subject, and deputations to Sir William Beveridge and Sir William Jowitt have consistently urged that the lot of such nurses should be safeguarded under the new National Insurance schemes. The College has also solicited the help of Members of Parliament in this matter, and when the National Insurance (Industrial Injuries) Bill came up for the second reading earlier in the month the Parliamentary Secretary to the Ministry of National Insurance, in response to Members' inquiries, assured the House that the Minister desired to provide for nurses and other health workers who had contracted diseases arising from their work, and suggested discussions on the matter between his Ministry and the Ministry of Health and those who could speak on behalf of the workers concerned. An impassioned appeal from Mr. Clitherow, on behalf of nurses and health workers who contract tuberculosis in the course of their work, was heard with much sympathy. In the past it has been necessary to *prove* that infection has been due to contact with patients in order to obtain compensation and as such infection cannot be perceived by the human eye and is, therefore, almost impossible of proof, compensation is usually withheld on legal grounds. It has recently been emphasized that in such cases the onus of proof should be upon the State to find good cause for supposing that the infection was *not* contracted during the course of employment, and this aspect should be given very serious consideration.

The problem is admittedly complicated, but the General Secretary of the Royal College was able to report that it had the sympathy of Government Departments, and that the present Minister of National Insurance would be glad to have the College's further views on the matter.

Entrance Qualifications for Student Nurses: Convinced that much of the high wastage among student nurses was due to the waiving, during the war, of any entrance qualifications for the profession, Council members discussed a preliminary report on the adaptation of methods of selection now employed in the Services and elsewhere to the nursing profession. A fuller report on the subject is in course of preparation. The Council warmly endorsed the principle that the candidates' ability to profit by her course of training *must* be assessed *before* entry to the hospital."

Nursing Sisters in Hong Kong

The following interesting letter has been received from Matron Olga H. Franklin, Q.A.R.N.N.S., from the Royal Naval Hospital, Sydney, N.S.W., Australia, dated October 28, 1945:

In September, 1944, the Japanese authorities released supplies for prisoners-of-war from the Canadian Red Cross Society, and amongst these were twenty comfort parcels addressed to Nursing Sisters, British Army, taken prisoner in Hong Kong, from the Canadian Nurses Association. Two nursing sisters and myself, members of Queen Alexandra's Royal Naval Nursing Service, had been working with members of Queen Alexandra's Imperial Military Nursing Service as one unit since leaving the Royal Naval Hospital, and their Matron, Miss E. M. B. Dyson, kindly included us when she distributed the parcels.

We now wish to thank you and all members of the C.N.A. for their kindness and great generosity. If only you could have seen the delight with which we unpacked the parcels and the comfort their contents gave, I feel you would have been rewarded.

The various articles were so carefully thought out, and the luxury of proper toothbrushes, soap, powder, etc., was a most joyful experience. Even the wrappings from soap gave us notepaper, and the cardboard boxes were used as cupboards or valuable fuel.

Will you please accept, and pass on to your members, our gratitude for the magnificent way in which Canadian friends of our profession were able to extend helping hands to us in a time of great necessity? The gift of the parcels will remain a happy highlight in our memories of the camp. Heartfelt thanks to you all.

Welcome to Nursing Sisters

We are most happy to welcome the Nursing Sisters home after a varied length of time from our shores. Many of these sisters are now taking postgraduate work in the various universities across Canada; others are already in their former positions in hospitals, public health, or in the private field of nursing. We wish them well in whatever field they choose.

Nurses' Relief

We wish to thank all the members of the Canadian Nurses Association, through the provincial associations, for the very generous response to our appeal for used coats, capes, and miscellaneous articles for the nurses of the Netherlands. These were shipped by Dutch boats directly from Montreal to the chairman of the Netherlands Nurses' Association, Amsterdam. We know the articles will be greatly appreciated by the Dutch nurses.

Placement Bureaux

The Placement Bureau Service is now operating, or about to operate, in seven of the nine provinces. Many letters have been received expressing appreciation for the privilege of attending the institute held in Winnipeg in September, 1945.

Women's Charter

Copies of the Women's Charter (the National Council of Women) were distributed, studied and recommendations made and forwarded from the provinces to National Office. These, in turn, have been referred to the representative who will be attending the next meeting of the National Council of Women in Toronto.

Provincial Association Reports

The Interim Reports of the Provincial Registered Nurses' Associations, as presented to the meeting of the Executive Committee, C.N.A., November 29, 30, and December 1, 1945, are here briefly summarized:

Alberta Association of Registered Nurses: Two seven-day institutes for industrial nurses were held in September—one in Calgary and one in Edmonton. The institute in Edmonton, held at the University of Alberta, was under the guidance of Miss Heide Henriksen, Industrial Nursing Consultant, Department of Health, University of Minnesota, Minneapolis. Miss Madeline McCulla, acting director of the School of Nursing, organized the course. These courses were very well attended.

Arising out of a resolution from the General Nursing Section at the annual meeting — "That adequate salary schedules for general duty nurses be arranged" — and from a letter to the Alberta Hospitals Association by an Albertan medical superintendent that the A.A.R.N. be asked to formulate policies with regard to salaries, hours of duty, vacation, sick leave with pay, hospitalization, and superannuation for all nurses employed in hospitals in Alberta, this "matter of salaries again came to the fore and activity has resulted." Committees of nurses, representative of each type of hospital whose employment policies were being discussed, met during July, 1945, to formulate provincial employment policies for staff nurses in Alberta hospitals. These were sent to the secretary of the board of each hospital in Alberta and to the superintendent of nurses of each hospital. Suggestions and criticisms were requested. A committee of nurses, representatives from the A.A.R.N., was asked to attend the Alberta Hospitals Association convention in Calgary, November 14, 15, and 16, to present the findings.

The Alberta Association of Registered Nurses asked the Canadian Passenger Association to grant railway rates for student nurses as for other students. This request was not granted.

The federal grant has made possible the appointment, for three months, of Miss Kathleen Herman, B.Sc. (in nursing), to teach public health nursing in nine of the eleven schools of nursing in the province. The other two schools have their own lecturers.

In September, 1945, a News Letter was sent to each hospital, hospital alumnae, provincial district, and to groups of nurses in doctors' offices, industries, and public health. Hospitals were asked to place their copies on the bulletin board and groups of nurses to pass their copies on to others.

Eleven students entering schools of nursing during the autumn of 1945 completed application forms for the Dominion-Provincial assistance for student nurses, for the grant of $100 each.

Registered Nurses' Association of British Columbia: The University of British Columbia reports a markedly increased enrolment of students in the nursing courses — 54 taking the public health course (13 of these students are ex-nursing sisters), 12 in teaching and supervision, and 24 in the prenursing course.

An institute for head nurses is planned for January, 1946. The guest speaker will be Mrs. Mary S. Tschudin from the University of Washington. It is hoped that head nurses will take advantage of this institute and that temporary relief will be forthcoming for local hospitals to cover the period when the head nurses are absent.

All student nurses in British Columbia are now required to have a course in tuberculosis nursing, approved by the R.N.A.B.C. and the Division of Tuberculosis Control of the provincial Board of Health. The Division of Tuberculosis Control is being requested to provide graduate experience, also, for nurses seeking reciprocal registration who did not have tuberculosis nursing experience in their undergraduate courses.

Consideration is being given by the R.N.A.B.C. to an expansion of the present psychiatric nursing affiliation course, with a view to the eventual inclusion of all students.

The responsibility for checking the educational credentials of applicants to schools of nursing has been assumed by the registrar. High school transcripts are submitted to the provincial office; if the applicant's record indicates completion of the required preliminary education, a qualifying certificate is sent to the school of nursing to which she is making application.

There have been fewer applications for Dominion-Provincial student nurse bursaries and loans than there were last year.

Shortage of nurses remains critical; the present listed vacancies are approximately 350. An appeal to private duty nurses to accept temporary staff positions during the vacation months resulted in a satisfactory response.

An experiment by the Vancouver Regional Branch in enrolling and placing practical nurses has been approved by the Council. This experiment will continue for one year. A study will be made at the end of six months to determine its value.

Manitoba Association of Registered Nurses: The Manitoba Association of Registered Nurses presented a brief to the Tuberculosis Control Commission containing the following recommendations:

1. That the Tuberculosis Control Commis-

sion establish a joint committee composed of three members appointed by the Commission and three nurse members nominated by the board of directors of the M.A.R.N.

2. That this joint committee undertake an immediate study of the various aspects of the tuberculosis affiliation problem in Manitoba and bring in recommendations to the Commission regarding:

(a) Existing facilities suitable for student nurse affiliation in Manitoba sanatoria.

(b) The requisite professional qualifications, preparation, salaries, living and working conditions for the nurse personnel charged with the responsibility of teaching and supervising affiliating students.

(c) The financial questions involved in the affiliation plan.

(d) Means of implementing the use of B.C.G. vaccine in schools of nursing.

One hospital has planned an affiliation program to commence in January, 1946.

Miss Frances Waugh is now engaged by the provincial Department of Health and Public Welfare as registrar and consultant for practical nurses.

New Brunswick Association of Registered Nurses: The New Brunswick Association of Registered Nurses reports having held a most successful and interesting institute for staff nurses, conducted by Miss Marion Lindeburgh of the McGill School for Graduate Nurses, in June, 1945.

Publicity in nursing has been carried on in the province by the convener and others, by holding conferences and career talks in high schools.

The general secretary attended the annual meeting held in Moncton.

In order to continue and expand the work of the nurse placement service, a brief is being prepared, asking for financial support from the provincial government, through the Minister of Health.

A joint meeting was held with representatives from the N.B.A.R.N. and a group of practical nurses who are anxious for help in securing legislation for practice.

Registered Nurses' Association of Nova Scotia: The general secretary and the editor of *The Canadian Nurse* were present at the annual meeting in New Glasgow.

A recommendation from the Hospital and School of Nursing Section that the R.N.A.N.S. adopt the policy of qualifying examinations at the end of the first year of the course in nursing was accepted and a committee was appointed.

The Public Health Section recommended that one regular branch meeting during the year be a public health meeting with a public health program.

A committee was formed, with Miss J. Forbes as convener, to explore the possibility of a Job Instruction Training institute for the R.N.A.N.S.

Recommendations from the General Nursing Section were as follows: (1) That the general staff nurses work on straight eight-hour duty throughout the province, with a minimum salary of $100 per month, and board and laundry when living out, with one day off a week, making a forty-eight hour week or ninety-six hour fortnight, and that this resolution be sent to the Maritime Hospital Association; (2) that whereas the private duty nurses of Nova Scotia are desirous of establishing a straight eight-hour day at $4.00 per day; Be it resolved that, where sufficient nurses are available, private duty nurses throughout Nova Scotia work a straight eight-hour day at $4.00 per day.

The following new committees were appointed: (1) One to study the advisability and possibility of university post-graduate courses for nurses in public health, teaching and supervision in schools of nursing, to be established in Halifax in conjunction with Dalhousie University; (2) a committee to study and revise the application form for registration; (3) that the local or district organization of the provincial registered nurses' association select three or more employee members who would inform themselves on labour conditions in their locality and be prepared to act, if asked, as a certifiable negotiating or bargaining group, either with or without representatives from the nurse employees affected in any disagreement.

A new branch of the R.N.A.N.S. has been opened, known as the Yarmouth-Shelburne Branch, with Miss Muriel Rice as president.

Registered Nurses Association of Ontario: There are now 22 community nursing registries organized within the province.

Due to the efforts of the associate secretary, the 500 copies of the first News Bulletin, which were sent out in August, proved a successful venture. The second issue will appear in November, when 7000 copies will be printed and sent to all members of the association.

A publicity folder, "The Challenge of Nursing", is now ready for distribution among students in secondary schools, drawing their attention to the opportunities in the nursing profession.

The sum of $5,000 has been received from the Ontario Department of Health, and a similar amount will be received before the end of the government fiscal year. This grant will assist in carrying on the work of the association.

A brief on Nursing Education was prepared by a special committee, to be submitted to the Royal Commission on Education in Ontario, of which the Honourable Mr. Justice J. A. Hope is chairman.

The associate secretary made an official visit to Districts 9 and 10 and expects to visit other districts in the future. Official visits from the provincial office to the districts are of great value in interpreting the work of the association.

Registered Nurses Association of Prince Edward Island: A brief for presentation to the provincial Committee on Reconstruction was reviewed at a special meeting.

A well-attended institute on supervision was conducted by Miss Marion Lindeburgh in June, 1945.

The committees on Legislation and on Health Insurance have been active and are planning more intensive study on these subjects.

Registered Nurses Association of the Province of Quebec: Miss Suzanne Giroux, R.R.C., began her duties as official visitor to the French schools of nursing in Quebec on October 15, 1945. Miss Giroux has recently returned from overseas where she served as matron of No. 17 Canadian General Hospital, R.C.A.M.C.

Three thousand copies of the translation of the sixth edition of Eliason, Ferguson, Farrand's textbook on Surgical Nursing were made available on September 1. It is interesting to note that these copies are being used not only on this continent but also in South America.

"Public Health Nursing" by M. Gardiner and the N.O.P.H.N. Manual are at present being prepared in French under the auspices of the French Public Health Section executive of the R.N.A.P.Q.

The lending library was increased by fifteen volumes during the summer months. This library, which is the result of voluntary efforts of the executive committee, Public Health Section (English group), is housed at R.N.A.P.Q. headquarters.

The association was fortunate in 1943 in securing amendments to the Registration Act. Junior matriculation is the educational requirement, to come into effect December 31, 1948. This means that no student should be admitted to provincial schools of nursing who does not meet this requirement.

McGill University has been approached in an effort to establish a plan whereby all credits presented with applications to nursing schools will be evaluated there, and a uniform statement designed by mutual agreement between the university and the board will be included in the record of each student. The reason for consulting the university and not the provincial Department of Education is that the Act states that any high school diploma or certificate presented must be sufficient for entrance into a university of the province. A copy of this record will come to the association with her entry into the qualifying examination.

The R.N.A.P.Q. now has twelve district associations and is working on a News Bulletin, similar to the one sent out by the Registered Nurses Association of Ontario.

Seven of the members have reported recently from UNRRA headquarters with the B.A.O., Rhine, Germany, and are serving near the former Belsen concentration camp.

Programs have been organized in the various sections. The English portion of the Public Health Section, under Miss M. Trueman's chairmanship, has organized small study groups which meet once a week. The study at present is "Child Care".

Distribution is being made of the International Council of Nurses pamphlet "What every nurse should know about the I.C.N." Publication of the French edition of this pamphlet is underway.

Four of the members, including the president, have been appointed to represent nurses (employees in hospitals) on the Parity Committee, which serves in an advisory capacity with regard to the functioning of the Labour Relations Act in relation to collective bargaining. The Act in question operates in Quebec City and northern provincial area. The R.N.A.P.Q. was given the legal right to bargain for the nursing staff of the Montreal Department of Health. The executive expects to secure this privilege in regard to every group of members wishing the association to act as their bargaining agent. To date, eight groups have signed such a petition.

Contact has been made with the director of Vocational Guidance, rehabilitation of service personnel, with regard to nursing, and many inquiries from all sources for data regarding courses for trained attendants have been received.

Saskatchewan Registered Nurses' Association: Miss M. Diederichs relinquished the office of president and was succeeded by Mrs. Dorothy Harrison.

Through a joint committee of the Saskatchewan Hospital Association, Saskatchewan Registered Nurses' Association, and the Saskatchewan College of Physicians and Surgeons, representations were made to the provincial government for financial assistance, to make immediate provision for extension of living accommodation in schools in which an increase of student enrolment could be effected under conditions approved by the S.R.N.A. The government accepted this responsibility, and to date one school has received this assistance. Other recommendations affecting nursing service were discussed with governmental authorities at this time and endorsed by them.

A legal adviser keeps the association in touch with any legislation which might affect nurses or nursing in the province.

Two more centres in Saskatchewan are organizing chapters, which will bring the total up to nine.

The District Officer Commanding has been most co-operative in advising the provincial association of the return of nursing sisters to the province. A letter of welcome has been sent to each, with an offer of advice or assistance in securing suitable placement, if desired.

General

The Minimum Curriculum (provincial) is being studied in some of the provinces with a view to possible revisions.

Developments of health, unemployment insurance, and labour relations continue to be matters of special interest and study.

Several of the provincial associations have submitted suggestions to Colonel Bovey, chairman of the Royal Commission on Veterans' Qualifications, with reference to training personnel in the three armed services for positions as nurses' aides.

The Value of Hospital Auxiliaries

JANE HOGARTH

The primary function of any auxiliary body is to take up the slack, to fill in any gaps, to augment the work of the regularly organized, official board. It is to accomplish these tasks that women's auxiliaries have been organized in conjunction with large and small hospitals all over Canada. Not the least of their obligations is to assist in building up community good-will and support for the hospital. This is particularly valuable in smaller cities and towns where perhaps one and, at the most, two hospitals have to serve a fairly wide area. The favourable publicity which an active women's auxiliary can provide assists greatly in securing community support for any form of hospital expansion which may be undertaken. It is true that the actual arrangements for raising large sums of money devolve upon the board, but before such a campaign can be successfully launched, whole-hearted, favourable community support must be built up. Here, the auxiliary's representatives from all the women's organizations in the area have an excellent opportunity to assist.

The first requisite of such an auxiliary, therefore, would be that it is representative of the widely-varied women's groups in the community. It is not enough that the wealthier, more social-minded women alone should be represented. When actual work has to be done, the rank and file of women are the ones who can accomplish most.

Not only should the auxiliary be socially representative, it should also have a good leavening of the younger women in the community, Only as they become interested, valued workers in the organization will the younger women be prepared to pick up the duties of their mothers and aunts when the latter find regular attendance at meetings too onerous. Since continuity in service is vital to the success of any well-run organization, it is obvious that there should be regular inductions of new members who will bring energy and enthusiasm to the task. Dead wood, disinterested members must be thoughtfully but frimly weeded out of the organization, if it is to continue strong.

This brings up another factor which must not be overlooked. Intermittent attendance at meetings tends to drain off enthusiasm. Even the most pressing need of the hospital appears of minor importance to the person who gives scantily of time and energy. While a roll-call of members is probably superfluous, some technique for ensuring regularity of attendance and punctuality is valuable.

Given an active, representative, responsibility-bearing organization and a capable, energetic executive, what opportunities are there for the hospital auxiliary to serve? A brief review of the role which the Ladies' Aid of the McKellar General Hospital in Fort William has filled since the beginning of this century will illustrate how valuable an auxiliary may prove.

When McKellar Hospital was in course of building, it was thought advisable to organize a hospital aid in connection with it, and for this purpose a public meeting was called in the Council Chamber, November, 1902, with the result that the aid was formed. Although this was the official organization of the Ladies' Aid, as early as 1893, a group of women, interested in the care of the sick and unfortunate, were members of a Relief Society which was organized when eighty immigrants were quarantined for smallpox outside the town. It is worthy of mention that there was only one death and not one outbreak in town. All the supplies were provided by the Relief Society, which continued its good work until district work was started in December, 1899, under the supervision of the Victorian Order of Nurses.

Miss Farnsworth, the first nurse, gave excellent service in district nursing but the need for a hospital was felt and, with a committee of both men and women supporting it, the work in the Victorian Cottage Hospital was begun in 1901. The cottage was fairly well supplied with modern conveniences, but had only a meagre supply of hospital wants and appliances. Accommodation was planned for seven, but there were seldom less than ten patients. From the Committee, a house committee with two men and two women were appointed each month. "Want Lists" were given to this committee and all necessities were quickly supplied. Soon the hospital became too small.

A group of citizens had been appointed to solicit subscriptions for a hospital. They were very successful in their efforts and in 1902 definite plans for building were made. On June 25, 1903, the hospital was ready for occupation. The Ladies' Aid supplied all that was lacking and made it for that time a splendidly equipped hospital. They were ever ready to help and there was encouragement and stimulus to the nursing staff in knowing that they had a faithful band giving of their time, thought and labour to keep the good work going. This society has been fortunate in its selection of presidents and other officers, each having adaptability to fill well her own position.

When the Aid was formed, different methods were discussed to ensure a large membership. It was finally decided that the collectors canvass their districts with that end in view. Soon over two hundred members were enrolled having paid their membership of one dollar. Members of the Aid travelled to White River, Schreiber and the surrounding districts soliciting subscriptions. Plans were made for a bazaar and work began. Sewing meetings continued until the end of April when the bazaar was held. It was an unqualified success. The proceeds of the first year's work were given to the hospital board to be applied to furnishings. For several years the bazaar was an annual event. Other means of raising money were rummage sales and dances which were held regularly and were very popular. Other organizations and societies put on concerts and other forms of entertainment, the proceeds of which were given to the Aid. A very successful undertaking was the printing of a 40-page special edition of the *Times Journal* on April 17, 1908, all copy of which had to do with the work of the women. The president, Mrs. T. M. Piper, was editor-in-chief and was given every assistance by all members of the Aid. When a house was rented to accommodate the nursing staff, the Ladies' Aid supplied the furnishings. Then again, when the nurses' home was built, they assisted with the furnishings.

From this beginning, McKellar Ladies' Aid has continued in the same spirit, desiring to help the sick and suffering, to provide more accommodation, more comforts in that home set apart to house the sick and afflicted. They have always been ready to assist those who are looking after the management. The aid still continues to buy furnishings and comforts for the nurses' home. A member of the first committee, Mrs. G. A. Coo, is still an active worker in the Aid being convener of the buying committee. The Aid has always assisted with the graduation exercises of the school and for many years has given prizes.

Mrs. A. V. Sinclair, president, McKellar Hospital Ladies' Aid, enumerates the present activities of the Aid:

> The main object of this organization is to supply the linens, etc., for the hospital. Every month the superintendent, Miss Waterman, sends in a list of requirements and these are filled as promptly as possible by our buying committee. At graduation time we give a scholarship of two hundred dollars to the student nurse taking the higest marks and a ten dollar prize for the student standing first in charting. In September, the Aid holds a market shower for the hospital and a good supply of vegetables, etc., is donated by the vendors. The membership drive takes place in the fall and the members canvass the city selling memberships to hospital. This is most successful. Before the war a jam, fruit and pickle shower was always held in October. This work will be resumed as soon as sugar rationing is abandoned. The members hold one big tea and bridge in January which proves very successful both financially and socially. All during the winter months, we meet once a week and make roses and violets for our annual Tag Day which is always held on Easter Saturday. Regular visits are made to the Old Ladies' Ward, their birthdays remembered and special treats given to them. We are now working toward a new hospital and have Victory Bonds put away to furnish a very special Ladies' Aid Ward. In order to keep in closer touch with the work of the hospital, the president now is a member of the Board of Trustees and attends all meetings.

From a nurse's point of view, I feel that a ladies' auxiliary is very necessary for any hospital, if they are as faithful and as co-operative as McKellar Hospital Ladies' Aid has always been.

Institute for Industrial Nurses

One of Alberta's recent projects has been an Institute in Industrial Nursing sponsored by the School of Nursing, Faculty of Medicine, University of Alberta, under the auspices of the Alberta Association of Registered Nurses and made possible financially through the federal grant, 1945-46.

With the growing interest in and expansion of the industrial nursing field, it had been felt for some time that some effort should be made to give guidance and assistance to nurses in industry. The need was discussed by the members of the Public Health Nursing Section of the Alberta Association of Registered Nurses, who formulated a resolution asking for some guided study, with the result that an institute was planned.

The nurses of Alberta were fortunate to secure an outstanding leader in industrial nursing in the person of Miss Heide Henriksen, industrial nursing consultant for the Minnesota State Department of Health and part-time lecturer at the University of Minnesota. Miss Henriksen who, through the kindness of the Department of Health and the University of Minnesota, was loaned to Alberta for a period of three weeks, conducted the institutes which were organized by Miss Madeline McCulla, acting director of the School of Nursing. University of Alberta.

The program was planned for the period of September 4 to September 20, 1945. Owing to the scarcity of relief help it was impossible for employers to grant leave of absence to the industrial nurses and thus lectures were limited to evening classes, while during the day Miss Henriksen and Miss McCulla paid visits to many representative public health and industrial persons and plants. Six evening sessions were offered in Edmonton and six in Calgary, with a total enrolment of fifty-five which included industrial nurses, nursing sisters, public health, private duty, and hospital staff nurses. The program was primarily planned for the nurse already in industry and for those who might at some future date become engaged in this field.

Alberta is not an industrial province but it has a number of small industries with approximately ninety thousand workmen who come under the Workmen's Compensation Act. Industries include mining, lumbering, gas and oil wells, packing plants, manufacturing and retail industries, etc. An interesting and promising regulation has recently been enforced by the Workmen's Compensation Board which calls for the employment of a graduate nurse in any industry of two hundred workers or more. Statistics have proven that the employment of a nurse in industry reduces the accident and sickness rates, reduces absenteeism, keeps the costs of production at a minimum, and preserves and promotes individual and family health. She is the individual whose responsibility it is to assist in planning health and safety programs and to inform and guide management in a co-operative, co-ordinated program for the benefit of workers and production.

Lectures and discussions included industrial nursing and what it entails; program planning, and the need for co-ordinated and integrated programs; the physical set-up of the plant infirmary; mental hygiene of the worker; eye accidents; the duties and preparation of the industrial nurse; the need for guidance and supervision in an in-service plan for training and continuous staff education.

The safety supervisor of the Workmen's Compensation Board was extremely cooperative and insisted that all industrial nurses grasp this opportunity provided by the A.A.R.N.

Gene Garrett Photo

HEIDE HENRIKSEN

STUDENT NURSES PAGE

Time Well Spent

JACQUELINE SKINNER

Student Nurse

School of Nursing, Jeffery Hale's Hospital, Quebec City

Ours was a community unique in itself. We were servicemen's wives, most of us brides, living in cottages that had been generously turned over for our use. We were seeking to make the most of what little time was left before our husbands were sent overseas. Our days were spent in friendly little groups, making post-war plans, knitting and sewing for the I.O.D.E. or the Red Cross, or doing social work in the community.

Changes occurred frequently in our little groups: new faces were silently welcomed in and, in the same silent way, familiar faces were lost. The words were never uttered and no farewells were spoken, but as each member dropped out we knew that another of "our boys" had received his orders. All this we accepted quietly, and each waited, knowing that at a moment's notice her turn would come and she must make her departure and follow some scheme to occupy her time.

Amongst us were teachers, nurses, social service workers, stenographers, designers, housewives—women from all walks of life. Each planned to go back to her own branch of work, and those of us who had no special training determined to do something about it. Several of my friends chose to do the same as I did. It was with high hopes that we applied at various schools of nursing and with deep gratification that we received letters of acceptance.

Life in a training school was a far cry from the life to which we had been accustomed, but it was not long till we were accepted as part of the bewildered groups that formed our classes and over which the warmth of a friendly atmosphere soon prevailed. Trying moments were numerous but they are short-lived in a training school, and new events crowded our days and captured our interest. Soon we learned that the ability to concentrate on the end in view is the best guarantee of real rewards; nursing became our chief interest and each day held something more thrilling that the last. We learned the nursing arts and sciences and put them into practice in the hospital. Even the smallest effort brought vast rewards. The satisfaction of a treatment well done; seeing activity restored to an incapacitated patient; the result of the action of medications given correctly and on time; the joy of seeing a new life ushered into the world, and the quiet dignity with which life ebbs out; the realization of the comforting effect of such simple things as a cleansing bath or a cooling alcohol rub to a bed patient; the satisfaction of being able to answer intelligently the patient's queries; the implicit trust with which a patient yields himself to treatment; the heart-warming smile of thanks for some small service rendered to a patient not able to care for his own wants — these are but a few of our rewards.

There were classes and clinics to attend; lectures given by the doctors under whom some day we would work; medical terms to learn, signs and symptoms, drugs and solutions; the use of our hands and ingenuity in the care of the sick — all the things a nurse must know to make a success of and uphold her profession.

It is hard to believe that over two years have slipped by since my training began, and each day passes more quickly than the last. Soon I will be a graduate nurse and the possessor of a cherished R.N. certificate. I know I will always look back on my days in training as well worthwhile, and I will never regret having chosen to make nursing my profession.

Book Reviews

Surgical Nursing, by E. L. Eliason, M.D., L. K. Ferguson, M.D., and E. M. Farrand, R.N. 585 pages. Published by J. B. Lippincott Co. Canadian office: Medical Arts Bldg., Montreal 25. 7th Ed. 1945. Price $3.50.

Reviewed by Winnifred MacLean, Surgical Supervisor, Royal Victoria Hospital, Montreal.

All who study this seventh edition will do so with pleasure, profit and new interest. There are over 250 well chosen illustrations, all with excellent teaching value, and for the first time several are in colour which brightens the pages and will enhance the interest of student and instructor.

The work has been completely revised. It is reset (with a carefully selected type face) in a double column which makes for easy and restful reading.

Teaching of the student, and student needs, are more than ever to the fore. Note the well-planned suggestions for nursing conferences and the list of special references and readings at the end of each unit.

Many paragraphs, presenting the newer trends and advances, are to be found throughout the text, as for instance, the nursing care in the administration of the sulphonamides and of penicillin. Under "Post-operative Positions in Bed" the student's attention is drawn to the "increasing tendency . . . to encourage more change of position and active exercise of the limbs early in the convalescence, etc."

The changes of the war years in the treatment of extensive burns are clearly presented, with illustrations, in Unit Six, with the use of blood plasma for shock, and pressure bandages for the burned areas described in detail. In this unit developments in Plastic or Reconstructive surgery are introduced for the first time.

The following brief excerpts illustrate the soundness of the teaching. We find under "The Nurse and Malignancy": "Tactfully refer all questions by the patient, the family, or his friends to the attending physician. This will avoid confusion and misinformation". Or, under "Prostheses": "Tactfully teach the patient early to be self reliant and helpful . . . in many ways that the intelligent thoughtful nurse can devise and put into practice". These are but two examples of the guidance the writers wish to give students for more thoughtful nursing care.

Certainly this is an excellent textbook for students, head nurses, and instructors — one that emphasizes equally the nursing care of the patient and the teaching of the student.

La Garde-malade en Chirurgie, par E. L. Eliason, M.D., L. K. Ferguson, M.D., et E. M. Farrand, R.N. 809 pages.

Publié par J. B. Lippincott Co. Office canadien: Medical Arts Bldg., Montreal 25. Traduction par le docteur J. A. Baudouin de la Sixième Edition (complètement revue et corrigée). Prix $3.50.

Revue par A. Martineau, assistante infirmière en chef, Service de Santé, Montréal, P.Q.

L'Association des Gardes-Malades Enregistrées de la Province de Québec, à la demande de quelques infirmières, tant laïques que religieuses, a fait traduire la sixième édition de "Surgical Nursing" d'Eliason, Ferguson, et Farrand pour le bénéfice des infirmières de langue française. Par conséquent "La Garde-malade en Chirurgie" est maintenant en vente chez nos libraires.

La chirurgie demande de la part de l'infirmière, autant de compréhension de son rôle que de dextérité pour l'accomplir, comme dans toute branche du nursing. Ne lisons-nous pas dans la préface:

"L'expérience a démontré que la garde-malade commet moins d'erreurs et fait un meilleur travail quand elle comprend non seulement ce qu'il faut faire, mais aussi la raison pour laquelle elle doit procéder d'une certaine façon".

Dans la composition de ce manuel les auteurs ont visé à améliorer la formation des étudiantes gardes-malades en rendant leur tâche plus intéressante et plus facile.

Ce manuel divisé en treize parties, traduit de façon impeccable, traite des maladies nécessitant des interventions chirurgicales et des divers traitements relevant de la chirurgie. On y trouve exposé avec simplicité, ordre et précision, non seulement les différentes techniques employées avec la liste du matériel requis mais encore, l'anatomie et la physiologie des organes atteints, le but et les avantages des opérations et des traitements, les complications susceptibles de survenir et les moyens d'y obvier.

L'espace dont je dispose ne me permet pas de commenter ni même d'énumérer les principaux points énoncés dans ce livre. Les auteurs n'ont rien négligé pour rendre plus compréhensible et plus accessible à l'infirmière cette vaste science qu'est la chirurgie. Toutefois, mentionnons en passant les nombreuses gravures et les illustrations variées qui donnent encore plus de clarté au texte.

L'étude sérieuse et approfondie de ce manuel aidera les gardes-malades étudiantes et diplômées à accomplir leur tâche avec plus de compétence procurant ainsi plus de bien-être au patient. L'infirmière hygiéniste bénéfiera également de ce manuel. Une infirmière désireuse de se documenter ou de parfaire ses connaissances sur les méthodes modernes de technique opératoire aseptique, ou encore, sur le drainage de l'estomac, l'instillation de l'oeil, etc., trouvera dans cette mine de renseignements tout ce dont elle a besoin.

L'apparition de "La Garde-malade en Chirurgie" comble un besoin existant et réalise un grand pas vers le progrès et l'avancement; car, il faut bien l'avouer les élèves gardes-malades ne sont pas trop favorisées en ce qui concerne les livres français. Un résumé des cours donnés par les professeurs est souvent la seule source de références mise à leur disposition surtout depuis la dernière guerre mondiale. Soeur Mance Décarie, hier encore, directrice de l'Ecole des Gardes-Malades de l'Hôpital Notre Dame écrit à ce sujet: "Cet ouvrage richement illustré esquisse une orientation sérieuse et nécessaire dans l'étude comme dans l'éducation de nos infirmières de langue française".

Nous sommes reconnaissantes à l'Association des Gardes-Malades Enregistrées d'avoir compris la nécessité pour les gardes-malades de langue française de posséder des manuels récents en facilitant cette traduction. Ce geste pose un jâlon vers l'acquisition de livres français. Souhaitons qu'il ne demeure pas isolé.

Il appartient donc aux infirmières diplômées de même qu'aux étudiantes de faire bon acceuil à ce manuel et d'en ormer les rayons de leurs bibliothèques afin d'y recourir au besoin. Les livres ne sont-ils pas nos meilleurs amis?

Nursing in Pictures, by Ella L. Rothweiler, M.A., R.N. Published by F. A. Davis Co. Philadelphia. Canadian agents: The Ryerson Press, 299 Queen St. W., Toronto 2B. 1st Ed. 1945. Price $6.25.

No expense has been spared in producing a text which outlines pictorially an infinitude of details of the nursing care provided in our hospitals. It is stated in the foreword that "This work makes no pretense to setting up a standard set of procedures". A perusal of the text accompanying each photograph shows the truth of this statement and indicates what might be called the chief weakness of the book. Since visual learning ranks high in teaching methods and since the photographs depict definite techniques, the occasional vague generalities in the text-material prove slightly disturbing. Nevertheless, the teaching content is good and can be thoroughly recommended as a student reference book or a refresher text for the older graduate.

Fundamentals of Psychiatry, by Edward A. Strecker, M.D. 222 pages. Published by the J. B. Lippincott Co. Canadian office: Medical Arts Bldg., Montreal 25. 3rd Ed. 1945. Price $3.75.

Written primarily for the physician, this interpretation of abnormal mental states has proven so satisfactory it is now in its third edition in as many years. The subject-matter is interwoven with illustrative stories. Line drawings and graphs clarify the textual material. The physical causes and manifestations of mental states are examined in detail. Methods of treatment for the various psychoses are described.

The last chapter is devoted to the work of the nurse in caring for psychiatric patients. Too few nurses have the requisite background of intuition, training and experience to realize all of the opportunities for service which are presented to them. This chapter draws attention to the little differences which it would benefit all those, who nurse the psychiatric patient, to understand.

Special mention should be made also of the chapter which outlines the various war neuroses and their treatment. While many of the details of treatment are beyond the nurse's scope, the basic factor is constant for all cases. "Rapid cure depends on food, sleep, exercise and the hopeful attitude of those who come in contact with the patients". This is the nurse's province and she must know how to carry out the doctor's instructions intelligently.

The Nurse, Handmaid of the Divine Physician, a Handbook of the Religious Care of the Patient, by Sister Mary Berenice (Beck). 359 pages. Published by J. B. Lippincott Co. Canadian office: Medical Arts Bldg., Montreal 25. 1945. Price $2.50.

Planned primarily as a handy reference book for Catholic nurses, this little volume contains "all of the necessary and much of the helpful information regarding the sacraments and other Catholic practices intended to console the sick and dying". Since much of the information relative to this type of consolation is unknown to the average non-Catholic nurse, the book has value for her also that she may adequately meet any of the demands which may be made upon her by her numerous Catholic patients.

Public Opinion on Health

Summarizing some of the public polls on health conducted by his organization, George Gallup in the July-August, 1945, issue of *Channels*, underlines Raymond Clapper's statement:

"Never overestimate the people's knowledge, nor understimate their intelligence".

In 1936, when newspapers and radios were afraid to mention venereal diseases, a Gallup poll revealed that 90 per cent of the people were in favour of starting an educational program and 88 per cent were in favour of establishing governmental VD clinics.

Public sentiment is 4-1 in favour of having sex hygiene taught in secondary schools.

Gallup polls have revealed that the people don't know as much as they should about the cause and prevention of disease, nor about diet.

Twenty-one per cent of the people think

cancer is contagious. Many people think it is caused by swallowing phlegm, by using certain kinds of cooking pots, by jealousy, resentment, or by thinking "bad thoughts". One out of every four persons is unaware of the fact that tuberculosis is contagious.

Alberta Department of Public Health

Jean Clark has been awarded a Rockefeller Foundation Fellowship to study in the United States for a year and *Sheila MacKay,* of the Hemaruka district, is now in the office as assistant to the superintendent of the Public Health Nursing Branch and the supervisor of the Health Education Division.

Wilma McCordick is taking the public health nursing course at the University of Alberta and *Kathleen Macdonald* will be stationed at Lindale.

Margaret Clark replaces *Dorothy Geeson* at Worsley. *Doris Haslam* is temporarily relieving at Smith. *Mrs. J. (Rowe) Perkins* is in the Wainwright Health District.

Mrs. Margaret Doerr has resigned from the Dixonville district and now is at Port Alberni, B.C. *Mrs. S. E. Heldal* has resigned from Whitemud Creek district. *Alice Hitz* has resigned from the Plamondon district to act as matron of Olds Municipal Hospital and *E. Standing* returns.

Ontario Public Health Nursing Service

Evelyn Watts (Hamilton General Hospital and University of Toronto public health course) has accepted an appointment with the Kenora Board of Health. *Edythe Weir* (St. Catharines General Hospital and University of Toronto public health course) has accepted an appointment with the Elgin County Health Unit. *Mary Anne Grandy* (Diploma course, University of Toronto School of Nursing) has accepted an appointment with the Porcupine Health Unit. *Ann MacFarland* (Children's Memorial Hospital, Montreal, and McGill University public health course) has accepted a position with the Nepean Township Board of Health to organize a generalized service.

Louise Grover (Toronto General Hospital and University of Toronto public health course) has resigned as public health nurse in the village and Township of Markham. *Jessie Smith* (Toronto General Hospital and University of British Columbia public health course) has resigned from the Newmarket Board of Health. *Mrs. Alex (Carlisle) Weremchuk* (Ontario Hospital, New Toronto, and University of Toronto public health course) has resigned from the staff of the Simcoe County School Health Unit.

Public Health Nursing Division, Toronto

The following nurses have recently been appointed to the Division of Public Health Nursing, Department of Public Health, Toronto:

Graduates of the *Toronto General Hospital* and University of Toronto School of Nursing: Elizabeth Barron, Almena Keddy, Ruth MacLennan, Irene McKelvey, Molly Rowe.

Graduates of the *Toronto Western Hospital* and University of Toronto School of Nursing: Margaret Boddy, Joy James.

Graduates of *St. Michael's Hospital, Toronto,* and University of Toronto School of Nursing: Elizabeth Foley, Madeline Herbert.

Graduates of *University of Toronto School of Nursing*: Dorothy Lough, Mrs. Noreen Powers.

Helene Boehme (Regina General Hospital, Sask.), Agnes Collver (Brantford General Hospital), Marie Cummings (Victoria Public Hospital, Fredericton), Lola Pearsall (St. Paul's School of Nursing, Saskatoon), Elma Reid (Women's College Hospital, Toronto). (All nurses have taken post-graduate courses at the University of Toronto School of Nursing.)

On Leave of Absence: Eileen Cryderman and Ruth Kent are engaging in further study in public health nursing. Miss Cryderman is taking the degree in nursing at Teachers College, Columbia University, and Miss Kent at the University of Toronto School of Nursing.

Resignations: Margaret Hunt, Mrs. Dorothy Marshall, Alice McGee, Mrs. Helen (Clarida) McInnis.

Retirements: Annie Connor, Bessie Elliott, Katharine Rouse.

Metropolitan Health Committee, Vancouver

Dorothea Shields has returned from a three-months course in communicable disease nursing in Michigan and has been appointed as consultant in communicable disease nursing.

The following nurses have recently been appointed to the staff of the Metropolitan Health Committee, Vancouver:

Betty Blanchard (St. Joseph's Hospital and University of B.C. public health course), *Jean Brumwell* (B.Sc., University of Alberta), *Florence Carter* (University of Alberta Hospital and University of Toronto public health course), *Mrs. Jean Dorchester* (Vancouver General Hospital and B.A.Sc., University of B.C.), *Jean Maxwell* (Ottawa Civic Hospital and University of Toronto public health course), *Margaret Miller* (Lamont Hospital and B.Sc., University of Alberta), *Annette Mongeau* (Holy Cross Hospital and McGill University public health course), *Mrs. Mabel Moulder* (Ottawa Civic Hospital and McGill University public health course), *Gwen Rogers* (Royal Columbian Hospital and University of B.C. public health course), *Mrs. Mina Tamblyn* (University of Toronto School of Nursing), *Marjorie Willis* (Vancouver General Hospital and University of B.C. public health course).

Elizabeth Copeland, who received a bursary award, has been granted a leave of absence to take the course in supervision and administration in public health nursing at the McGill School for Graduate Nurses.

The following resignations have recently been accepted: *Mrs. Margaret Allan* (B.A. Sc., University of B.C.); *Louise Drysdale* (Royal Columbian Hospital and University of B.C. public health course), appointed to School Board staff in September, 1926, as supervisor of Unit 2 in 1938, to go into business; *Mary Dunn* (M.A., Columbia University), to join UNRRA staff; *Madeline Herbert* (University of Toronto public health course), to return to Toronto; *Mrs. Isabelle Petrie* (M.A., Columbia University), to live in Winnipeg; *Phyllis Scouler* (University of B.C.), to join the V.O.N.

M.L.I.C. Nursing Service

Following are recent changes in the personnel of the Metropolitan Life Insurance Company Nursing Service:

Louise Ahier (Notre Dame Hospital, Montreal) has resigned from the Company's service. Miss Ahier was on the Montreal staff.

Willa Ahern (Ottawa General Hospital, and McGill University public health course) recently returned from military service, and has been posted for a temporary period in

Montreal, whence she will proceed to Sudbury, Ontario, to take charge of the Company's nursing service. Miss Ahern joined the R.C.A.M.C. as nursing sister in February, 1942.

Marie E. Cantin (St. Vincent de Paul Hospital and University of Montreal public health course) will spend from eight to ten weeks in Atlanta, Georgia, taking a course of instruction at the Company's training centre. Miss Cantin is educational director for Metropolitan nursing staffs in Montreal.

Claire Champagne (Ste. Justine Hospital, Montreal, and University of Montreal public health course) recently resigned from the Company's service. Miss Champagne had been in charge of the nursing service in Rivière du Loup, P.Q.

Monette Gervais (St. François d'Assise Hospital, Quebec City, and University of Montreal public health course) recently was transferred from the Montreal to the Quebec City nursing staff.

Catherine Lamarre, Jeannette Sylvain (both graduates of l'Hôpital de l'Enfant Jesus, Quebec City), and *Agnes Taschereau* (Notre Dame Hospital, Montreal) have been appointed to the Montreal nursing staff.

Liane Chevalier (St. Jean de Dieu Hospital, Gamelin) was recently transferred from Montreal to take charge of the nursing service in Joliette.

Madeleine Bulteau (Ste. Jeanne d'Arc Hospital, Montreal, and University of Montreal public health course), formerly Metropolitan nurse in Joliette, has resigned from the Company's service. *Magdeleine Laniel* (Notre Dame Hospital, Montreal), of the Montreal nursing staff, has resigned from the Company's service.

Saskatchewan Public Health Nursing Service

M. E. Pierce and *M. P. Edwards* are on leave of absence for six months taking the course at the Lobenstein Maternity Centre in New York. *C. Boyko* received a Canadian Nurses Association bursary and with *S. Bayard* is taking the course in public health nursing at McGill University.

The following nursing sisters, recently discharged from the R.C.A.M.C., have joined the staff of the Division of Public Health Nursing: *J. Armstrong, A. Halabuza, M. E. Edmands, S. Brett* and *Mrs. M. E. Gleadow. J. Armstrong* is taking the course in public health nursing at the University of British Columbia. *Mrs. Gleadow* will be the nurse with the Air Ambulance Service recently established by the Department of Public Health.

Other appointments to the staff are: *R. Anton* and *N. M. Warren* (St. Paul's Hospital, Saskatoon); *I. Hjertaas* (Misericordia Hospital, Winnipeg); *E. Mathews* (Winnipeg General Hospital); *I. E. Paton* (Regina General Hospital); *Mrs. A. H. Woods* and *V. Johnson* (Saskatoon City Hospital).

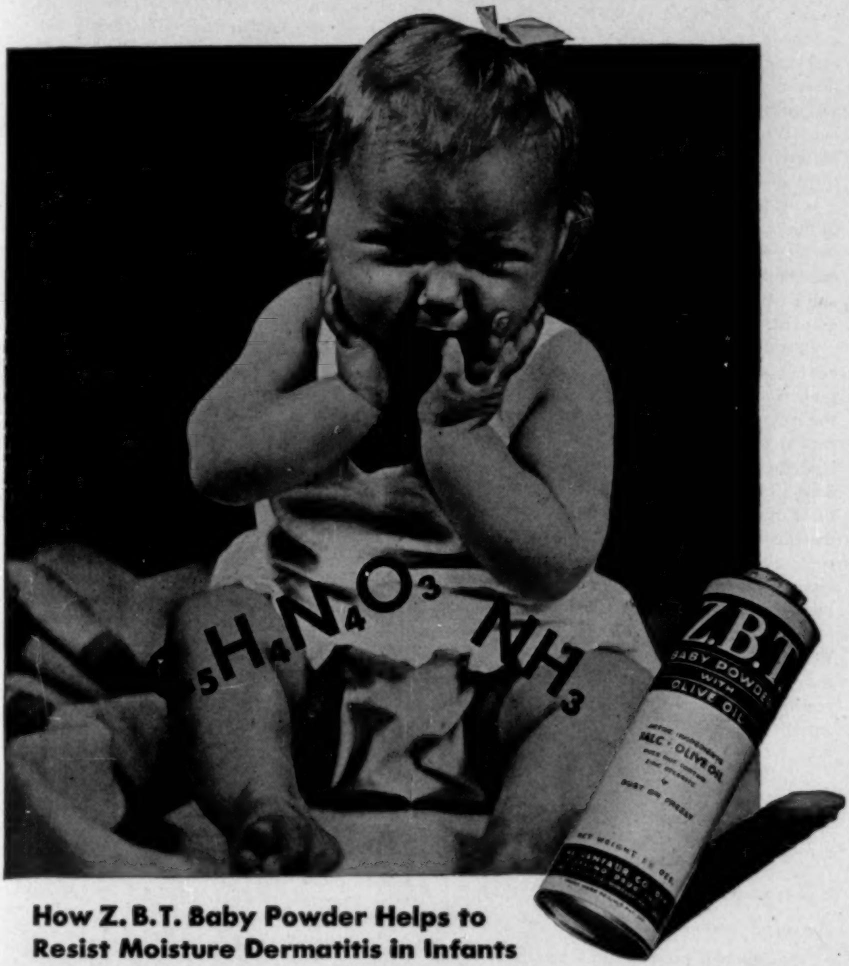
Mrs. Ken (Langstaff) MacRae recently resigned and now resides in Yorkton.

Nursing Sisters' Association of Canada

Calgary Unit reports that they have a paid-up membership of thirty-three, with seven meetings held during the year. Forty-five were present at the annual Remembrance Day tea, including seventeen nursing sisters as guests. On November 11 a poppy wreath was placed on the Cenotaph. On Decoration Day flowers were placed on graves of nursing sisters and of the husbands of two of the members. The association had charge of arrangements for the Vesper Services held last May.

Guests present at the March meeting were Gertrude Hall, of Montreal, Mrs. O. J. O'Driscoll, returned from Africa, and Miss Bibby, returned from Holland. H. B. Acton,

What is "Acid-Moisture"?



How Z. B. T. Baby Powder Helps to Resist Moisture Dermatitis in Infants

Dermatitis in infants brought about by wet diapers, clothes and bed clothes is a common and troublesome condition. Because of it the busy physician is often faced with questions from anxious mothers. While normally acid because of uric acid content ($C_5H_4N_4O_3$), urine is sometimes converted into an alkaline irritant in the "ammoniacal diaper" by urea-formed ammonia (NH_3).

On the basis of simple mechanical protection, the use of Z.B.T. Baby Powder with olive oil helps to resist moisture dermatitis. Z.B.T. clings and covers like a protective film—lessens friction and chafing of wet diapers and shirts. The mechanical moisture-resisting property of Z.B.T. may be clearly demonstrated. Smooth Z.B.T. on the back of your hand. Sprinkle with water or other liquid of higher or lower pH. Notice how Z.B.T. Baby Powder keeps skin dry as the drops roll off. Compare with any other baby powder.

Z. B. T.—the only baby powder made with olive oil

head nurse at the Calgary tuberculosis clinic, has resigned after eighteen years of service. Mrs. A. G. Cockrill has left Calgary to take up residence in Toronto.

Edmonton Unit: Services in all war activities have been suspended with the exception of one day a month at the Stamp Bar and monthly visits to patients in the Mewburn Wing and at the Convalescent Hospital. Fifteen dollars has been voted for "treats" to be distributed on these occasions.

In November about twenty members met at the home of Mrs. C. M. (Jephson) Greenwood who, with Mrs. W. (Walker) Joyce, entertained them to excellent "post-war eats" and a "freedom of speech" pastime was much enjoyed.

Parcels are being sent overseas to some of our members' families. A donation has been made to the "Not-Forgotten" fund for the veterans in hospital. A raffle and tea earned $425.56 which was sent to the Civilian Nurses Air-Raid Victims Fund in London. Frances Goodall, general secretary of the Royal College of Nursing, acknowledged the cheque, saying that many nurses who had suffered injuries and loss of their homes and belongings would receive benefits through the kindness of Canadian nurses.

Wreaths were laid on the Cenotaph on Remembrance Day. A "get-together" with the Canadian Corps was held later when refreshments and a sing-song were much enjoyed.

Halifax Unit: Although the war is over members continue to help in different ways. Several nursing sisters attended the Vesper Services held in May. The annual dinner was held in November, with twenty-two World War I and thirty-two World War II nursing sisters present, including three principal matrons and three matrons. Mrs. Beatie, the president, welcomed the new nursing sisters to the N.S.A. of Nova Scotia and they were awarded one year's complimentary membership. Many were in attendance at the Remembrance Day service at the Cenotaph where a wreath was placed by P/M R. L. King, R.R.C. and Matron M. B. McNeil, R.R.C.

Officers elected for 1945-46 include: president, Marion Haliburton and secretary, Edna C. Duthie.

Victoria Unit: At the annual tea the following officers were elected: president, C. Maney; secretary, W. Dowding; treasurer, Mrs. D. M. McAuley.

Two very successful bridge parties were held during the year. Proceeds from one was sent to the British Minesweepers Auxiliary. Activities in the Red Cross work room were discontinued in October. Members helped on Poppy Day and placed a wreath on the Cenotaph on November 11.

A letter stating the aims of the association, with a cordial invitation to join, was sent to all known returned nursing sisters of World War II.

NEWS NOTES

ALBERTA

EDMONTON:

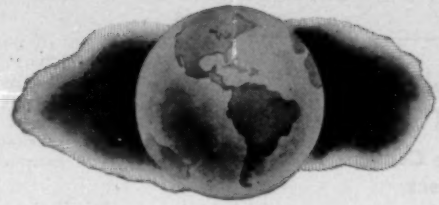
Royal Alexandra Hospital:

V. Chapman presided at a recent meeting of the Royal Alexandra Hospital Alumnae Association with fifty-two members present. The following conveners were appointed to take charge of the booths at the bazaar: Aprons, Mrs. N. Richardson, H. Adams; babies' knitted goods, A. Culshaw, Mmes P. Baker, E. Brennan; children's wear, F. Morrison, Mrs. J. Rowlatt; toys, D. Burry, O. Podborsk, E. Forestell; home cooking, A. Anderson, Mrs. C. McManus; miscellaneous, Mmes T. M. Blacklock, M. H. Thompson. The nurses now residing in Vancouver and Victoria are assisting with this effort. After the business meeting Major E. Day gave an interesting talk on "Rehabilitation". Major Day has recently returned from overseas and is now associated with the Department of Veterans Affairs. N/S Ethelwyn (Coupland) White told of her experiences in Sicily and Italy where she went with the invasion troops.

A substantial sum, contributed by the members, has been donated to the relief fund for nurses in Holland. Miss Chapman stressed the need for more members to become subscribers to their own national nursing *Journal*.

At a later meeting, with forty members in attendance, a film entitled "Student Nurse" was shown. This was produced in England for the Queen Elizabeth Fund and depicted the training and activities of the student nurse from the probation period until she became a State Registered Nurse.

We are pleased to report that over $700 was realized from the bazaar which was officially opened by Mrs. J. W. Fry, wife of the mayor of Edmonton. Margaret Fra-



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University of Manitoba
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THE VICTORIAN ORDER OF NURSES FOR CANADA

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Registered nurses without preparation will be considered for temporary employment.

Apply to:

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Chief Superintendent
114 Wellington Street,
Ottawa.

ser, superintendent of nurses and honourary president of the alumnae, with Violet Chapman, the president, received the guests. Articles for sale were received from R.A.H. graduates in Toronto, Calgary, Victoria, Vancouver and Edmonton, and a grateful "Thank You" is extended to all.

University Hospital:

At a recent regular meeting of the University of Alberta Hospital Alumnae Association there were forty members present. The treasurer, Velma Clark, reported that $160 had been realized from the dance held in October. Ten dollars was voted towards the Community Chest Fund. D. Guild and Mrs. G. Sleath gave reports on the work of the Edmonton District, A.A.R.N., for the past three months. Sheila MacKay of the Alberta Department of Public Health showed two films produced in Alberta. One depicted a summer school in public health held for the teachers in the Lamont Health Unit. The second pictured the research being done on Rocky Mountain spotted fever in southern Alberta.

After reading a letter from Margaret Kerr, editor of *The Canadian Nurse,* the association decided to sponsor a contest to help increase subscriptions to the *Journal* and to stimulate interest in its contents. (See page 18 for details of this contest.)

Over 150 Edmonton nurses recently gathered at the Col. Mewburn Pavilion auditorium to see medical films presented by the Alumnae Association. The Administration of Anesthesia by the Open Drop Ether Method proved most instructive. The excellent photography and the demonstrations of actual cases made the lessons very clear. All the pitfalls and their prevention were explained, both in the modern hospital and remote country districts. The treatment and diagnosis of neuro-psychiatric patients from this war in one of England's large hospitals was portrayed in "Neuro-Psychiatry". "Life Cycle of the Pin Mould" was a bacteriological film showing the growth of this mould from its earliest stages. "Revival of Organisms" was a USSR film, showing the work of their scientists on the revival of dogs some minutes after apparent death.

Student nurses from the University Hospital assisted alumnae members in serving lunch where nurses from the various hospitals became better acquainted.

BRITISH COLUMBIA

ALBERNI CHAPTER:

Every second Monday of each month the Alberni Chapter, R.N.A.B.C., holds a meeting at the Somas Hotel. The chapter is now well established with an average of twelve to twenty-four members in attendance. Following the business of each meeting, talks and illustrations on nursing subjects and those of general interest have been much enjoyed. For the past year the chapter's social events have been held with a view to raising funds for various worthy causes. Donations to war funds, a hospital library for patients and nurses, and the furnishing and decoration of a nurses' room at the hospital have been realized. Each chapter meeting is followed by refreshments thanks to our small but energetic social committee.

The officers for the current year include: president, Mrs. G. M. Webb; secretary, Mrs. L. K. Thomson; treasurer, Miss Brand.

ROSSLAND CHAPTER:

A regular meeting of the Rossland Chapter, R.N.A.B.C., was recently held when routine business was transacted and plans made for the season. Miss Kennedy, public health nurse for Rossland, and Mrs. Sommerville, formerly of Trail, were welcomed as new members.

At the kind invitation of Trail Chapter, six members of the Rossland Chapter attended a recent meeting to hear Miss E. Braund, director of the R.N.A.B.C. Placement Service. Miss Braund spoke on the value of placement service to the graduate nurse and explained how it functioned. A social hour followed.

NOVA SCOTIA

GLACE BAY:

St. Joseph's Hospital:

At a recent regular meeting of St. Joseph's Hospital Alumnae Association a scholarship committee was formed consisting of Mrs. D. Fraser, Mrs. S. Turner, and a member of school of nursing faculty.

Margaret McDonald is now superintendent of the War Veterans Hospital in Sydney. Previously, Miss McDonald was in charge of the Marine Hospital in that city. She was a nursing sister during World War 1.

G. Lee and J. O'Toole, recently returned from overseas, are now members of the staff in the same hospital.

ONTARIO

Editor's Note: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Gena Bamforth, 54 The Oaks, Bain Ave., Toronto 6.

Baby comes First
BABY'S OWN SOAP

Faced with a temporary shortage of certain raw materials necessary for the maintenance of the high quality of Baby's Own Soap, we ask the indulgence of all those who use or recommend it, to reserve the available supply for Baby.

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For further information apply to:

Miss Caroline Barrett, R.N., Supervisor of the Women's Pavilion, Royal Victoria Hospital, Montreal, P. Q.

or

Miss F. Munroe, R. N., Superintendent of Nurses, Royal Victoria Hospital, Montreal, P.Q.

REGISTERED NURSES' ASSOCIATION OF BRITISH COLUMBIA

Placement Service

Information regarding positions for Registered Nurses in the Province of British Columbia may be obtained by writing to:

Elizabeth Breund, R.N., Director
Placement Service
1001 Vancouver Block, Vancouver, B.C.

DISTRICT 1

CHATHAM:

Public General Hospital:

The last meeting of 1945 took the form of a social evening with Deby Hooper and Mrs. Phyllis Nichols in charge. The tea and bazaar were a great success swelling the funds of the alumnae to a substantial amount. Contributions were made as follows: $100 to the educational fund; $100 as final payment on the room in the new residence; $25 to the nurses' room in the hospital.

A subscription to the *Journal* was given to the high school library in the hope that it may serve in recruiting new members to the nursing profession.

DISTRICTS 2 AND 3

WOODSTOCK:

At the recent annual meeting of Districts 2 and 3, R.N.A.O., held in the Epilepsy Division, Ontario Hospital, Woodstock, with Mrs. K. Cowie, the chairman presiding, the following officers were elected: chairman, D. Arnold; vice-chairmen, M. L. Kerr, M. Grieve; secretary-treasurer, M. Patterson; section conveners: general nursing, A. Sobisch; hospital and school of nursing, M. Snider; public health, Miss Law; councillors: Brant, H. Cuff; Waterloo, R. Parkhouse; Wellington, E. Lunau; Dufferin, I. Shaw; Oxford, Mrs. J. Sanders; Huron, W. Dickson; membership convener, K. DeMarsh. There was a registration of 124 members and guests.

The invocation was given by the Rev. John Morris and Dr. Ernest Clark, superintendent of the hospital, delivered the address of welcome. Dr. W. H. K. Ross, staff physician, rendered two solos.

Reports were given as follows: treasurer's report showed a bank balance of $111.69 plus two $100 Victory Bonds; general nursing section, E. Clark; hospital and school of nursing section, G. Westbrook; public health section, M. Grieve; report of Kitchener-Waterloo Chapter, R. Bagshaw; fund for overseas clothing and capes for nurses in Holland, A. Savage; nominating committee, Miss Winterhalt.

The members were taken on a short tour through part of the epileptic cottages and then Mrs. J. Sanders introduced Dr. Clifford V. Tisdale, director of the Mental Health Clinic at the Ontario Hospital, who gave an interesting outline of the treatment of epilepsy. After a delicious dinner Mrs. Edward

Ferguson spoke on the "Life of Melina Rorke in Africa and England".

DISTRICT 6

BELLEVILLE:

Twenty-six nurses from Peterborough recently journeyed to Belleville to attend the annual meeting of District 6, R.N.A.O. which was held at the General Hospital. The business session was attended by representatives from Cobourg and Port Hope, making a total of fifty members. A successful year was reported by all the committees and an outline of meetings held by the three chapters showed activities increasing. An election of officers for the coming term was conducted by L. Stewart of Peterborough. The guests were shown through the hospital by Una McComb, secretary of Chapter A. A delicious supper was later served by the hospital staff.

The evening session opened with Dr. Russell Scott of Belleville as guest speaker. Dr. Scott, recently returned from England, was attached to the Basingstoke Neurological and Palstic Surgery Hospital. He chose as his subject "Plastic Surgery", and explained the treatment given and operations performed in the different types of injuries, such as burns, grafting, etc. His interesting address was illustrated by pictures of patients who came under his care and were proof of the wonders performed in this line of surgery.

PRINCE EDWARD ISLAND

CHARLOTTETOWN:

P.E.I. Hospital:

N/S Bessie J. MacKenzie, who served overseas with No. 7 Canadian General Hospital, has been awarded the A.R.R.C. Katheryn MacKenzie has received her discharge from the army and has accepted a position with the Souris Hospital, King's Co.

SUMMERSIDE:

Prince County Hospital:

Florence Yeo and Helen Small are now on the O.R. staff of the P.C.H. June Dalgill, O.R. supervisor at the P.C.H., resigned to accept a position on the staff of the University Hospital, Edmonton. Vera Allen has been released from the army and is doing general duty while Jean Fraser is nursing in Montreal.

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REGISTERED NURSES' ASSOCIATION OF BRITISH COLUMBIA
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An examination for the title and certificate of Registered Nurse of British Columbia will be held March 12, 13, and 14, 1946.

Names of Candidates for this examination must be in the office of the Registrar not later than February 12, 1946.

Full particulars may be obtained from:

ALICE L. WRIGHT, R.N., Registrar
1014 Vancouver Block, Vancouver, B.C.

QUEBEC

MONTREAL:

Children's Memorial Hospital:

The following nurses are now members of the staff of the C.M.H.: Dorothy Goulet (St. Mary's Hospital, Montreal); Mildred Hyslop (Montreal General Hospital); Brenda Carter (Royal Columbian Hospital, New Westminster); Yaeko Nagai (Vancouver General Hospital); Pauline Wright (Royal Jubilee Hospital, Victoria). The latter three have recently completed their post-graduate course at the C.M.H.

Laura Gray, formerly infant ward supervisor and social convener, has resigned and is now home in Ottawa. The resignations of Verona Day, Denise Dumaine, Mary Rogers, and Kathleen Wilson have been accepted.

The following nurses are enrolled in the new post-graduate class: Edna Daniel (Edmonton General Hospital); Norma Lee (Royal Victoria Hospital, Montreal); Jean McDonnell (St. Joseph's Hospital, Victoria); Yuki Nishimura (Regina Grey Nuns' Hospital); Beryl Robinson (Saskatoon City Hospital); Grace Whitehead (P.E.I. Hospital, Charlottetown).

Royal Victoria Hospital:

Lillian MacKenzie, director, City Health Nursing Division, Winnipeg, who has been on a three-month Rockfeller travel grant visiting health agencies in Canada and the United States, recently visited the school on her way home. N/S Olive Rand recently called at the hospital on her return from France where she served with the American Army. Mrs. J. J. (Lamont) MacArthur, of West McBride, Scotland, who has been spending some time in Canada, was a visitor at the school on her way home.

Pearl Murray is in charge of Ward A, replacing Irene Jackson. Alice Stevens has resigned as assistant head nurse on the fifth floor, Ross Pavilion, and has been replaced by Eileen McCarthy. Queade Bingham has resigned as assistant supervisor, Ross Pavilion, to be married.

QUEBEC CITY:

Jeffery Hale's Hospital:

Gertrude Hall, general secretary, C.N.A., addressed a recent meeting of the Alumnae Association. Her interesting subject, "Bridges to the Future", gave an insight into the trends of nursing education of tomorrow. A very successful bridge and social evening was recently held, under the auspices of the alumnae, to raise funds for the Frances Laurie scholarship fund. The nursing staff recently entertained at tea in honour of N. Fulton, who has resigned as supervisor of the operating room. She will be replaced by N. Humphries who is taking a post-graduate course in operating room technique at the Toronto General Hospital.

R. White has resigned as supervisor of the women's medical and semi-private wards and has been replaced by R. Manderson. E. Coull has resigned as supervisor of the pediatric ward and semi-private floor, and has been replaced temporarily by Mrs. M. Bent. E. MacMurray is taking a course in x-ray technique at the Royal Victoria Hospital, Montreal. The following nursing sisters have returned from overseas: D. Briggs, J. Warren, M. Quail, M. Green, M, Levi, J. Andrews, M. Matthews.

SASKATCHEWAN

HUMBOLDT:

Constance Elrick and Ethel Cruickshank (St. Elizabeth's Hospital) have taken positions on the staff at the hospital in Estevan.

PRINCE ALBERT:

Fifty-six nurses, representing twenty-two schools of nursing, recently attended a dinner meeting of Prince Albert Chapter, District 1. A musical program was presented by the student nurses of the Holy Family Hospital. Grace Giles addressed the nurses and held a short contest based on the September issue of *The Canadian Nurse*.

Rev. Sr. M. Loretta has returned to the Holy Family Hospital from Saint John, N. B., and is now instructress in the nursing school. A gift was presented to Mrs. L. J. Waine on her much regretted departure from Prince Albert. She was an ardent supporter of the local association.

SASKATOON:

R. Kirby, recently discharged from the R.C.A.M.C., is senior night supervisor at the City Hospital. During her overseas service Miss Kirby saw duty in England and Sicily. Beryl Robinson is taking a post-graduate course at the Children's Memorial Hospital, Montreal. Joan Whitney, now stationed in Winnipeg with the R.C.A.M.C., will soon obtain her private pilot's license. She has been taking flying lessons in her spare time and has several solo hours to her credit

WEYBURN CHAPTER:

Last October the Weyburn Chapter, District 8, held their first meeting, the organization of which has been confirmed by the S.R.N.A. The following officers were elected: president, Mrs. H. Mitchell; vice-president, M. MacDonald; secretary-treasurer. F. Rudeen; executive, Mrs. D. Jardine, P. Templeton.

L. Harris, superintendent of nurses, Weyburn Mental Hospital, recently visited psychiatric hospitals in the east. M. MacDonald, matron at the general hospital, recently attended the nurses' conference at Yorkton. Miss Halladay was in charge during her absence.

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Superintendent, Cornwall General Hospital, Cornwall, Ont.

WANTED

A Night Supervisor is required for an 80-bed hospital in **Southern Ontario.** Apply, stating full particulars, in care of:

Box 11, The Canadian Nurse, 522 Medical Arts Bldg., Montreal 25, P. Q.

WANTED

Applications are invited for the following positions in a 50-bed hospital:
Fully qualified **Operating Room Supervisor** at a salary of $95 per month, with full maintenance.
Laboratory and **X-Ray Technician** at a salary of $90 per month, with full maintenance.

Apply, giving qualifications and references, to:

Blanchard-Fraser Memorial Hospital, Kentville, N. S.

WANTED

Verdun Protestant Hospital desires applications from nurses for **General Staff Duty.** State in first letter, date of graduation, experience, and when services would be available. Registered Nurses are also required for the position of **Assistant Night Supervisor** and as **Charge Nurses** for wards. Apply to:

Director of Nursing, Verdun Protestant Hospital, Box 6034, Verdun, P. Q.

WANTED

Applications are invited for the following positions in the **Prince County Hospital:**

Superintendent
Assistant Night Superintendent

Apply at once by mail, stating experience, and salary required, to:
Secretary, Prince County Hospital, Summerside, P.E.I.

WANTED

A **Night Supervisor**, with experience in Supervision, is required for a large General Hospital in **Southern Ontario.** Apply, stating qualifications and salary expected. in care of:

Box 15, The Canadian Nurse, 522 Medical Art Bldg., Montreal 25, P.Q.

WANTED

An **Educational Director** is required for a School of Nursing connected with a large General Hospital in **Central Ontario.** Applicants must be qualified to teach Nursing Sciences. Post-graduate course in teaching and teaching experience essential. Apply, stating qualifications and salary expected, in care of:

Box 14, The Canadian Nurse, 522 Medical Arts Bldg., Montreal 25, P. Q.

WANTED

A qualified **Surgical Nurse,** with special training, is required for a 150-bed institution in the **Maritimes.** Apply, stating preparation, salary expected, and date available, in care of:

Box 10, The Canadian Nurse, 522 Medical Arts Bldg., Montreal 25, P. Q.

WANTED

An **Instructress of Nurses** is required for the **Kenora General Hospital.** Duties are to commence on **February 1.** Apply to:

Superintendent, Kenora General Hospital, Kenora, Ont.

WANTED

A class room **Instructress** for a 120-bed hospital. Apply stating qualifications, experience and salary expected, to:

The Superintendent, Stratford General Hospital, Stratford, Ont.

WANTED

A qualified **Instructress** is required **immediately** for the **Portage la Prairie General Hospital.** Apply, stating qualifications, experience, and salary expected, to:

Superintendent, Portage la Prairie General Hospital, Portage la Prairie, Man.

WANTED

Floor Duty Nurses are required at the **Barrie Memorial Hospital.** The salary is **$85.00** per month. Apply to:

Superintendent, Barrie Memorial Hospital, Ormstown, P. Q.